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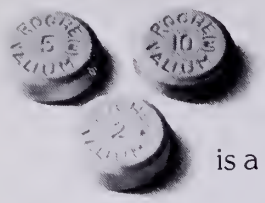
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THE FLORIDA MEDICAL ASSOCIATION INC



JANUARY 1980 • VOL 67 • NO

A character all its own.



Valium (diazepam/Roche) is a benzodiazepine with a character all its own. Pharmacologically, it is a potent skeletal muscle relaxant and anticonvulsant (in adjunctive use), as well as an antianxiety agent. Pharmacokinetically, only Valium provides active *diazepam* as well as the active metabolites 3-hydroxydiazepam, desmethyldiazepam and oxazepam.

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Another important aspect of the clinical character of Valium is safety. Though drowsiness, ataxia and fatigue are possible, these and more serious side effects are rarely a problem. Of course, as with all CNS-acting drugs, patients taking Valium should be cautioned against driving, operating dangerous machinery or the simultaneous ingestion of alcohol.

Unquestionably, many psychotherapeutic agents, including other benzodiazepines, have antianxiety effects. But one fact remains: you get a certain kind of patient response with Valium. It's a response you want. A response you know. A response you trust as part of your overall management of anxiety and psychic tension.

Valium® (IV)
diazepam/Roche

2-mg, 5-mg, 10-mg scored tablets

a prudent choice in psychic tension and anxiety

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children.* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10.

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This beautiful specimen of brain coral was captured photographically by Mr. Peter Van Houten, a second-year medical student at the University of Miami. The picture was made in 10 to 15 feet of water in the out islands of the Bahamas.

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Brief Summary of Prescribing Information

Indications and Usage: Symptomatic relief of anxiety, tension, agitation, irritability and insomnia associated with anxiety neuroses and transient situational disturbances, anxiety associated with depressive symptoms and as a treatment of symptoms of anxiety if such symptoms are a significant feature of functional or organic disorders, particularly gastrointestinal or cardiovascular

Effectiveness in long-term use, i.e., more than 4 months, has not been assessed by systematic clinical studies. Reassess periodically usefulness of the drug for the individual patient.

Contraindications: Known sensitivity to benzodiazepines or acute narrow-angle glaucoma.

Warnings: Not recommended in primary depressive disorders or psychoses. As with all CNS-acting drugs, warn patients on lorazepam not to operate machinery or motor vehicles, and of diminished tolerance for alcohol and other CNS depressants.

Physical and Psychological Dependence. Withdrawal symptoms like those noted with barbiturates and alcohol have occurred following abrupt discontinuance of benzodiazepines (including convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Addiction-prone individuals, e.g. drug addicts and alcoholics, should be under careful surveillance when on benzodiazepines because of their predisposition to habituation and dependence. Withdrawal symptoms have also been reported following abrupt discontinuance of benzodiazepines taken continuously at therapeutic levels for several months.

Precautions: In depression accompanying anxiety, consider possibility for suicide.

For elderly or debilitated patients, initial daily dosage should not exceed 2mg to avoid oversedation.

Terminate dosage gradually since abrupt withdrawal of any antianxiety agent may result in symptoms like those being treated: anxiety, agitation, irritability, tension, insomnia and occasional convulsions.

Observe usual precautions with impaired renal or hepatic function.

Where gastrointestinal or cardiovascular disorders coexist with anxiety, note that lorazepam has not been shown of significant benefit in treating gastrointestinal or cardiovascular component.

Esophageal dilation occurred in rats treated with lorazepam for more than 1 year at 6mg/kg/day. No effect dose was 1.25mg/kg/day (approximately 6 times the maximum human therapeutic dose of 10mg/day). Effect was reversible only when treatment was withdrawn within 2 months of first observation. Clinical significance is unknown; but use of lorazepam for prolonged periods and in geriatric patients requires caution and frequent monitoring for symptoms of upper G.I. disease.

Safety and effectiveness in children under 12 years have not been established.

ESSENTIAL LABORATORY TESTS: Some patients have developed leukopenia; some have had elevations of LDH. As with other benzodiazepines, periodic blood counts and liver function tests are recommended during long-term therapy.

CLINICALLY SIGNIFICANT DRUG INTERACTIONS: Benzodiazepines produce CNS depressant effects when administered with such medications as barbiturates or alcohol.

CARCINOGENESIS AND MUTAGENESIS: No evidence of carcinogenic potential emerged in rats during an 18-month study. No studies regarding mutagenesis have been performed.

PREGNANCY: Reproductive studies were performed in mice, rats, and 2 strains of rabbits. Occasional anomalies (reduction of tarsals, tibia, metatarsals, malrotated limbs, gastroschisis, malformed skull and microphthalmia) were seen in drug-treated rabbits without relationship to dosage. Although all these anomalies were not present in the concurrent control group, they have been reported to occur randomly in historical controls. At 40mg/kg and higher, there was evidence of fetal resorption and increased fetal loss in rabbits which was not seen at lower doses. Clinical significance of these findings is not known. However, increased risk of congenital malformations associated with use of minor tranquilizers (chlordiazepoxide, diazepam and meprobamate) during first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, use of lorazepam during this period should almost always be avoided. Possibility that a woman of child-bearing potential may be pregnant at institution of therapy should be considered. Advise patients if they become pregnant to communicate with their physician about desirability of discontinuing the drug.

In humans, blood levels from umbilical cord blood indicate placental transfer of lorazepam and its glucuronide.

NURSING MOTHERS: It is not known if oral lorazepam is excreted in human milk like other benzodiazepines. As a general rule, nursing should not be undertaken while on a drug since many drugs are excreted in milk.

Adverse Reactions, if they occur, are usually observed at beginning of therapy and generally disappear on continued medication or on decreasing dose. In a sample of about 3,500 anxious patients, most frequent adverse reaction is sedation (15.9%), followed by dizziness (6.9%), weakness (4.2%) and unsteadiness (3.4%). Less frequent are disorientation, depression, nausea, change in appetite, headache, sleep disturbance, agitation, dermatological symptoms, eye function disturbance, various gastrointestinal symptoms and autonomic manifestations. Incidence of sedation and unsteadiness increased with age. Small decreases in blood pressure have been noted but are not clinically significant, probably being related to relief of anxiety.

Overdosage: In management of overdosage with any drug, bear in mind that multiple agents may have been taken. Manifestations of overdosage include somnolence, confusion and coma. Induce vomiting and/or undertake gastric lavage followed by general supportive care, monitoring of vital signs and close observation. Hypotension, though unlikely, usually may be controlled with Levarterenol Bitartrate Injection U.S.P. Usefulness of dialysis has not been determined.

Ativan® (lorazepam) for Anxiety

Dosage: **Individualize for maximum beneficial effects. Increase dose gradually when needed, giving higher evening dose before increasing daytime doses. Anxiety, usually 2-3mg/day given b.i.d. or t.i.d.; dosage may vary from 1 to 10mg/day in divided doses. For elderly or debilitated, initially 1-2mg/day; insomnia due to anxiety or transient situational stress, 2-4mg h.s.**

How Supplied: **0.5, 1.0 and 2.0mg tablets.**

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Why one benzodiazepine and not another?

Are you concerned about long-acting metabolites? Many clinicians, as well as pharmacologists, are beginning to draw attention to this problem (see New England Journal of Medicine, April 5, 1979).

In contrast to some older benzodiazepines, Ativan (lorazepam) does not give rise to long-lasting active metabolites. As with all benzodiazepines, you should follow the usual precautions concerning co-administration with other CNS depressants and warn your patients against operating dangerous machinery and motor vehicles.

However, it is noteworthy that Ativan showed no clinical evidence of accumulation even when given in high doses over periods up to 6 months. The half-life of free lorazepam is about 12 hours; steady-state serum levels are attained in 2-3 days. Comparable data for diazepam: 20-50 hours and at least 7-10 days. (The pharmacokinetic profile of a drug can define such characteristics as absorption, distribution, metabolism and elimination but cannot, at present, be directly related to its therapeutic effectiveness.)

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See important information on preceding page.

Ativan® (lorazepam)
for Anxiety



President's Page

Meeting With The Press

Sitting around the table with a newspaper editorial board presents remarkable challenges and opportunities for the guest. Exchanging ideas with these powerful opinion makers can influence the attitudes and reactions of the public to entire institutions in our society.

In pursuit of improved understanding by newspapermen of medicine's aspirations and problems, the FMA leadership recently journeyed to the board rooms of all of Florida's largest circulation dailies. We did not go as a supplicant seeking a special consideration or a hand out. We did go in search of understanding and trust.

At the outset it must be said that almost all with whom we spoke were attentive, interested, and engaged in meaningful dialogue. We found, however, we were challenged to prove our positions were in the public interest. It must be remembered cynicism is a major defense against being misled and a key tool in the news business. It was particularly interesting to note the papers of largest circulation appeared to share medicine's social concerns the most.

We laid out three issues for discussion. These related to medical liability claims and their resurgence; recent discussions in Tallahassee about abolishing county health departments, and the FMA's program for public education on physical fitness.

The medical malpractice liability issue from a news standpoint is obviously the most interesting and provided the major portion of the discussion.

The liability issue transcends the concerns of the health industry and pervades all sectors of the economy. As a result it is suggested by many that the inflationary effect of the multitudinous and massive liability claims must be dealt with if our precarious economy is to meet its international challenges.

In this light a significant number of our press contacts agreed that a fair, constitutional and politically possible approach to tort reform should be considered. A recommendation of the FMA to the Legislature will be one designed to balance the equities between plaintiff and defendant. A key element of this proposal will be to provide for recovering the costs of defense and attorney's fees from the plaintiff, in cases of successful defense in any civil liability action before a court or administrative panel. In cases where the presiding judge determines indigency on the part of the plaintiff, defense cost assessment could be waived.

This proposal is simply an extension of the present law which provides for recovery of defense costs when suits are dismissed summarily as containing no justiciable issue. The proposal should also extend to all civil liability actions and not be limited solely to assertions of medical malpractice.

The other issues relating to county health departments and the FMA physical fitness program generated little discussion with the editors. There was, however, considerable interest on the part of some of the press in receiving and perhaps publishing material from future editions of *The Journal* relating to the general area of physical fitness.

The overall impression which we gained from these visits was that our reception and conversations were warmer and more fruitful when the local county medical society had a record of cordial relations with the media. In a few cases, we were able to clear up some misunderstandings between the county medical society and the local paper.

It's a worthwhile lesson for all of us to learn that newspapers are obligated to report news. Some reporting decisions are difficult and delicate. In this light, we have an obligation to assist the press in doing its job. Unfortunately an overzealous crusading paper or an overly sensitive protectionist medical society can create barriers that are difficult to break down.

At this point some direct discussion can be fruitful. In any event regular communication with the local media is vital. A written code for medical information should allow for meaningful reporting, including direct quotes of physicians, when a specific patient is not involved. When a commentary on medical news is made by reporters or editors, editors should carefully examine all sides of the issue before establishing policy. Medical spokesmen ought to be solicited for comment before editorials are written. The editorial page is not the place for sensationalism or hypocrisy. The medical society is not the place for protectionism through secrecy.

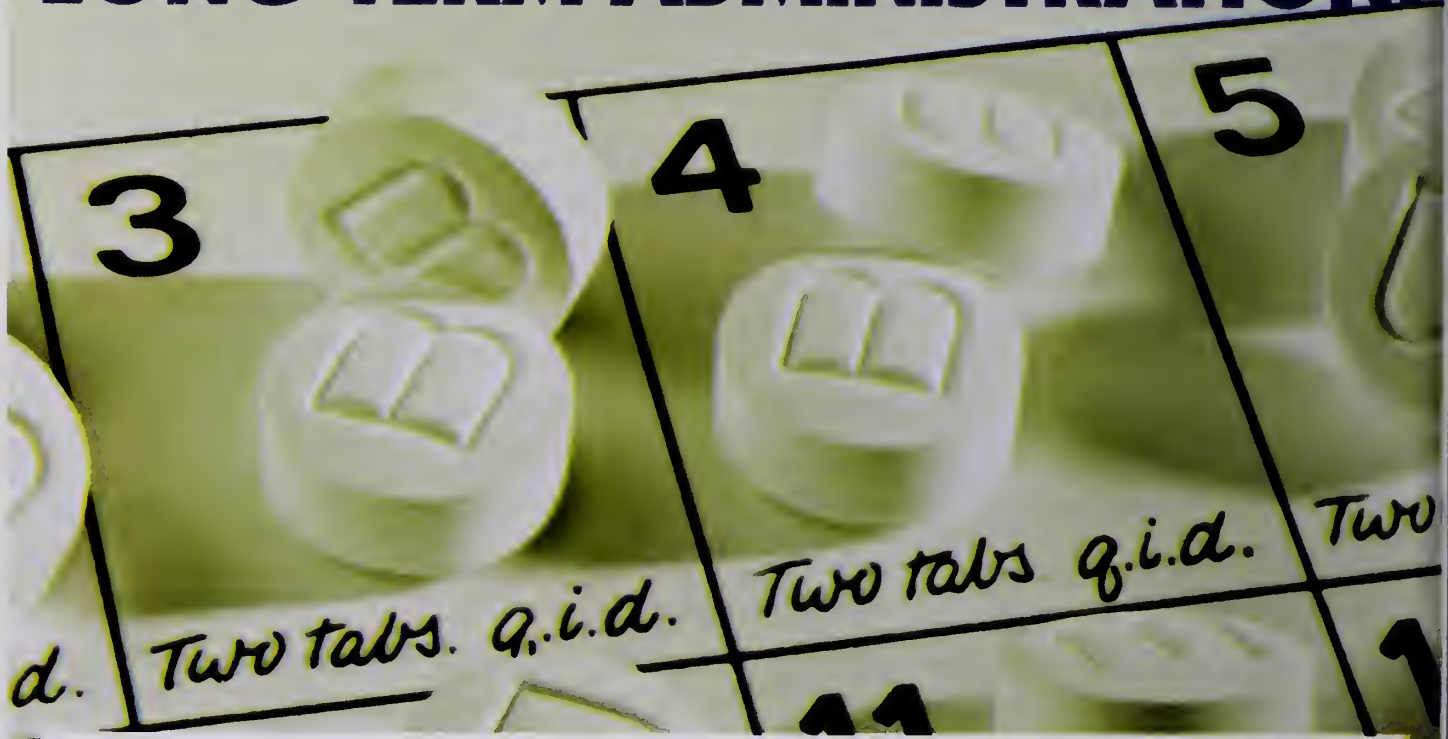
A climate of openness and trust between the news media and organized medicine in this state will yield significant benefits to the health of all Floridians. And the health of Floridians is, after all, what the FMA is all about.

Richard Hodes

The noblest sort of man emphasizes the good qualities in others, and does not accentuate the bad the inferior does the reverse. The noblest sort of man pays special attention to nine points: He is anxious to see clearly, to hear distinctly, to be kindly in his looks, respectful in his demeanor, conscientious in his speech, and earnest in his affairs. When in doubt, he is careful to inquire; when in anger, he thinks of the consequences; when offered an opportunity to gain, he thinks only of his duty. — Confucious

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Dean's Page

No One Product

Hollis G. Boren, M.D.

The fact that the academic health centers of this country are one of our greatest national resources requires that they are responsive to multiple legitimate priorities and societal demands. These demands also vary over the years and so pose an additional dimension to the demands made on Colleges of Medicine, Nursing, Allied Health Sciences and University Teaching Hospitals.

One only need recall the most recent responsibilities of Colleges of Medicine to gain a valuable perspective. Examples are the production of a great many more physicians, to produce more primary care physicians, and to provide access to all minorities to a first class medical education. Examples from Colleges of Nursing and Colleges of Allied Health Sciences are equally impressive.

The steady and often explosive technologic advances of a University Teaching Hospital require urgent and comprehensive exploration of entire new disciplines. Computerized axial tomography, one of the most recent additions to our diagnostic methodology possesses many complex problems for training, evaluation and validation of utilization as well as careful consideration of cost factors. The utilization of each advance in technology which involves patients has an urgency not usually found in other applications of scientific advances.

Although it is highly desirable to have well ordered priorities and "up front" commitments from all persons involved in policy decisions, such a condition is not always possible in our profession. In addition to the changing demands made upon us, we must operate in a multi-layered bureaucracy of health planners at all levels of our professional lives with great loss of time and efficiency.

Fortunately there is an answer to the demands and responsibilities made on our medical system and has been woven into the fabric of organized medicine since the beginning. This answer lies in the flexibility and in the ability of our medical institution to adapt that which equals our biologic systems. One way of expressing this characteristic of our system is that medical schools do not produce one given stereotype called physician. We produce no one product. Instead we train physicians who maintain and express their individual talents to their fullest extent. It really makes no difference whether a given physician is a family practitioner, a medical or surgical specialist, or a basic or clinical research scientist; the field is so broad and all encompassing that individual physicians may be widely divergent in their goals and careers and the full potential of our system can still be realized. It is through such diversity that we are able to respond responsibly to both patient and societal demands.

Dr. Boren is Director of the University of South Florida Medical Center and Dean of the College of Medicine, Tampa.

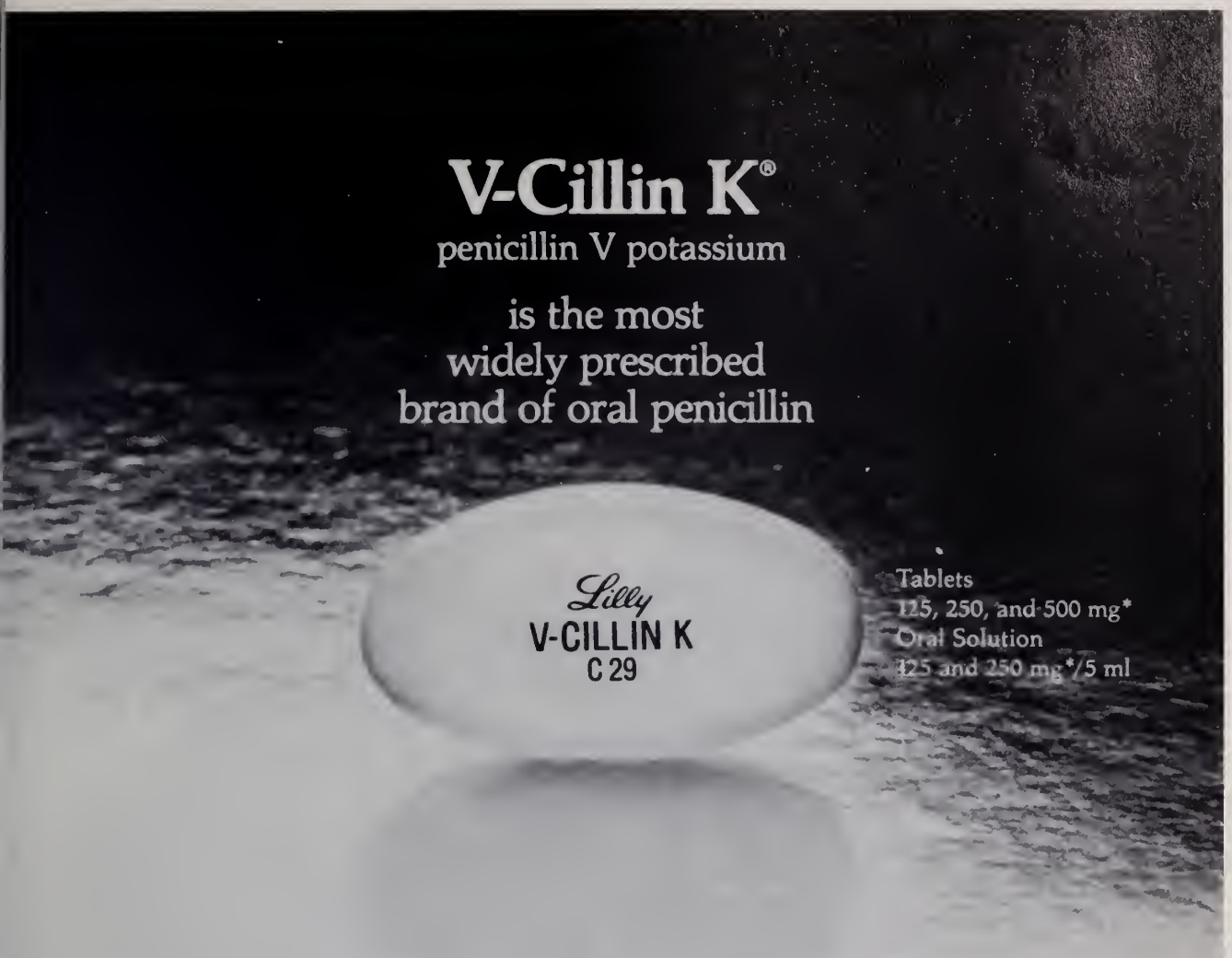
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Warnings: Serious, occasionally fatal, anaphylactoid reactions have been reported. Some patients with penicillin hypersensitivity have had severe reactions to a cephalosporin; inquire about penicillin, cephalosporin, or other allergies before treatment. If an allergic reaction occurs, discontinue the drug and treat with the usual agents (e.g., epinephrine or other pressor amines, antihistamines, or corticosteroids).

Precautions: Use with caution in individuals with histories of significant allergies and/or asthma. Do not rely on oral administration in patients with severe illness, nausea, vomiting, gastric dilatation, cardiospasm, or intestinal hypermotility. Occasional patients will not absorb therapeutic amounts given orally. In streptococcal infections, treat until the organism is eliminated (minimum of ten days). With prolonged use, nonsusceptible organisms, including fungi, may overgrow; treat superinfection appropriately.

Adverse Reactions: Hypersensitivity, including fatal anaphylaxis. Nausea, vomiting, epigastric distress, diarrhea, and black, hairy tongue. Skin eruptions, urticaria, reactions resembling serum sickness (including chills, edema, arthralgia, prostration), laryngeal edema, fever, and eosinophilia. Infrequent hemolytic anemia, leukopenia, thrombocytopenia, neuropathy, and nephropathy, usually with high doses of parenteral penicillin. (102175)

***Equivalent to penicillin V.**

Additional information available to the profession on request.

Lilly

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900416


getting back
to business

with symptomatic relief of moderate anxiety with depression

Rapid relief of anxiety

The tranquilizer component alleviates symptoms of anxiety within a few days without apparent dulling of mental acuity. Hypnotic effects appear to be minimal, particularly in patients permitted to remain active. However, TRIAVIL may impair mental and/or physical abilities required for the performance of hazardous tasks.

Dependable antidepressant action

The antidepressant component relieves symptoms of depression such as poor concentration and feelings of hopelessness as well as early morning awakening; adequate relief of symptoms may take a few weeks or even longer.

for moderate anxiety with depression

dual-action **Triavil**®

containing perphenazine and amitriptyline HCl

Treatment with TRIAVIL—a balanced view

TRIAVIL is contraindicated in CNS depression from drugs, in the presence of evidence of bone marrow depression, and in patients hypersensitive to phenothiazines or amitriptyline. It should not be used during the acute recovery phase following myocardial infarction or in patients who have received an MAOI within two weeks. Patients with cardiovascular disorders should be watched closely. Not recommended in children or during pregnancy. TRIAVIL may enhance the response to alcohol. Antiemetic effects may obscure toxicity due to overdosage of other drugs or mask other disorders. The possibility of suicide in depressed patients remains until significant remission occurs. Such patients should not have access to large quantities of the drug. Hospitalize as soon as possible any patient suspected of having taken an overdose.

MSD
MERCK SHARP & DOHME

Please see the following page for a brief summary of prescribing information.

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by providing symptomatic relief of moderate anxiety with depression

dual-action Triavil®

containing perphenazine and amitriptyline HCl

helps patients get back to business

Available:
TRIAVIL® 2-25: Each tablet contains
2 mg perphenazine and 25 mg amitriptyline HCl.
TRIAVIL® 2-10: Each tablet contains
2 mg perphenazine and 10 mg amitriptyline HCl.
TRIAVIL® 4-50: Each tablet contains
4 mg perphenazine and 50 mg amitriptyline HCl.
TRIAVIL® 4-25: Each tablet contains
4 mg perphenazine and 25 mg amitriptyline HCl.
TRIAVIL® 4-10: Each tablet contains
4 mg perphenazine and 10 mg amitriptyline HCl.

CONTRAINDICATIONS: Central nervous system depression from drugs (barbiturates, alcohol, narcotics, analgesics, antihistamines); evidence of bone marrow depression; known hypersensitivity to phenothiazines or amitriptyline. Should not be given concomitantly with a monoamine oxidase inhibitor since hyperpyretic crises, severe convulsions, and deaths have occurred from such combinations. When used to replace a monoamine oxidase inhibitor, allow a minimum of 14 days to elapse before initiating therapy with TRIAVIL. Therapy should then be initiated cautiously with gradual increase in dosage until optimum response is achieved. Not recommended for use during acute recovery phase following myocardial infarction.

WARNINGS: TRIAVIL should not be given concomitantly with guanethidine or similarly acting compounds since TRIAVIL may block the antihypertensive action of such compounds. Use cautiously in patients with history of urinary retention, angle-closure glaucoma, increased intraocular pressure, or convulsive disorders. Dosage of anticonvulsive agents may have to be increased. In patients with angle-closure glaucoma, even average doses may precipitate an attack. Patients with cardiovascular disorders should be watched closely. Tricyclic antidepressants, including amitriptyline HCl, have been reported to produce arrhythmias, sinus tachycardia, and prolongation of conduction time, particularly in high doses. Myocardial infarction and stroke have been reported with tricyclic antidepressant drugs. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. May impair mental and/or physical abilities required for performance of hazardous tasks, such as operating machinery or driving a motor vehicle. In patients who use alcohol excessively, potentiation may increase the danger inherent in any suicide attempt or overdosage. Not recommended in children or during pregnancy.

PRECAUTIONS: Suicide is a possibility in depressed patients and may remain until significant remission occurs. Such patients should not have access to large quantities of this drug.

Perphenazine: Should not be used indiscriminately. Use with caution in patients who have previously exhibited severe adverse reactions to other phenothiazines. Likelihood of some untoward actions is greater with high doses. Closely supervise with any dosage. The antiemetic effect of perphenazine may obscure signs of toxicity due to overdosage of other drugs or make more difficult the diagnosis of disorders such as brain tumor or intestinal obstruction. A significant, not otherwise explained, rise in body temperature may suggest individual intolerance to perphenazine, in which case discontinue.

If hypotension develops, epinephrine should not be employed, as its action is blocked and partially reversed by perphenazine. Phenothiazines may potentiate the action of central nervous system depressants (opiates, analgesics, antihistamines, barbiturates, alcohol) and atropine. In concurrent therapy with any of these, TRIAVIL should be given in reduced dosage. May also potentiate the action of heat and phosphorous insecticides. There is sufficient experimental evidence to conclude that chronic administration of antipsychotic drugs which increase prolactin secretion has the potential to induce mammary neoplasms in rodents under the appropriate conditions. There are recognized differences in the physiological role of prolactin between rodents and humans. Since there are, at present, no adequate epidemiological studies, the relevance to human mammary cancer risk from prolonged exposure to perphenazine and other antipsychotic drugs is not known.

Amitriptyline: In manic-depressive psychosis, depressed patients may experience a shift toward the manic phase if they are treated with an antidepressant. Patients with paranoid symptomatology may have an exaggeration of such symptoms. The tranquilizing effect of TRIAVIL seems to reduce the likelihood of this effect. When amitriptyline HCl is given with anticholinergic agents or sympathomimetic drugs, including epinephrine combined with local anesthetics, close supervision and careful adjustment of dosages are required. Paralytic ileus may occur in patients taking tricyclic antidepressants in combination with anticholinergic-type drugs.

Caution is advised if patients receive large doses of ethchlorvynol concurrently. Transient delirium has been reported in patients who were treated with 1 g of ethchlorvynol and 75-150 mg of amitriptyline HCl.

Amitriptyline HCl may enhance the response to alcohol and the effects of barbiturates and other CNS depressants.

Concurrent administration of amitriptyline HCl and electroshock therapy may increase the hazards associated with such therapy. Such treatment should be limited to patients for whom it is essential. Discontinue several days before elective surgery if possible. Elevation and lowering of blood sugar levels have both been reported. Use with caution in patients with impaired liver function.

ADVERSE REACTIONS: Similar to those reported with either constituent alone.
Perphenazine: Extrapyramidal symptoms (opisthotonus, oculogyric crisis, hyperreflexia, dystonia, akathisia, acute dyskinesia, ataxia, parkinsonism) have been reported and can usually be controlled by the concomitant use of effective antiparkinsonian drugs and/or by reduction in dosage, but sometimes persist after discontinuation of the phenothiazine.

Tardive dyskinesia may appear in some patients on long-term therapy or may occur after drug therapy with phenothiazines and related agents has been discontinued. The risk appears to be greater in elderly patients on high-dose therapy, especially females. Symptoms are persistent and in some patients appear to be irreversible. The syndrome is characterized by rhythmical involuntary movements of the tongue, face, mouth, or jaw. Involuntary movements of the extremities sometimes occur. There is no known treatment for tardive dyskinesia; antiparkinsonism agents usually do not alleviate the symptoms. It is advised that all antipsychotic agents be discontinued if the above symptoms appear. If treatment is reinstituted, or dosage of the particular drug increased, or another drug substituted, the syndrome may be masked. Fine vermicular movements of the tongue may be an early sign of the syndrome. The full-blown syndrome may not develop if medication is stopped when lingual vermiculation appears.

Other side effects are skin disorders (photosensitivity, itching, erythema, urticaria, eczema, up to exfoliative dermatitis); other allergic reactions (asthma, laryngeal edema, angioneurotic edema, anaphylactoid reactions); peripheral edema; reversed epinephrine effect; hyperglycemia; endocrine disturbances (lactation, galactorrhea, gynecomastia, disturbances of menstrual cycle); altered cerebrospinal fluid proteins; paradoxical excitement; hypertension, hypotension, tachycardia, and ECG abnormalities (quinidine-like effect); reactivation of psychotic processes; catatonic-like states; autonomic reactions, such as dry mouth or salivation, headache, anorexia, nausea, vomiting, constipation, obstipation, urinary frequency or incontinence, blurred vision, nasal congestion, and a change in pulse rate; other adverse reactions reported with various phenothiazine compounds, but not with perphenazine, include grand mal convulsions, cerebral edema, polyphagia, pigmentary retinopathy, photophobia, skin pigmentation, and failure of ejaculation.

The phenothiazine compounds have produced blood dyscrasias (pancytopenia, thrombocytopenic purpura, leukopenia, agranulocytosis, eosinophilia) and liver damage (jaundice, biliary stasis).

Pigmentation of the cornea and lens has been reported to occur after long-term administration of some phenothiazines. Although it has not been reported in patients receiving TRIAVIL, the possibility that it might occur should be considered.

Hypnotic effects, lassitude, muscle weakness, and mild insomnia have also been reported.

Amitriptyline: Note: Listing includes a few reactions not reported for this drug, but which have occurred with other pharmacologically similar tricyclic antidepressant drugs and must be considered when amitriptyline is administered. *Cardiovascular:* Hypotension; hypertension; tachycardia; palpitation; myocardial infarction; arrhythmias; heart block; stroke. *CNS and Neuromuscular:* Confusional states; disturbed concentration; disorientation; delusions; hallucinations; excitement; anxiety; restlessness; insomnia; nightmares; numbness, tingling, and paresthesias of the extremities; peripheral neuropathy; incoordination; ataxia; tremors; seizures; alteration in EEG patterns; extrapyramidal symptoms; tinnitus; syndrome of inappropriate ADH (antidiuretic hormone) secretion. *Anticholinergic:* Dry mouth; blurred vision; disturbance of accommodation; increased intraocular pressure; constipation; paralytic ileus; urinary retention; dilatation of urinary tract. *Allergic:* Skin rash; urticaria; photosensitization; edema of face and tongue. *Hematologic:* Bone marrow depression including agranulocytosis; leukopenia; eosinophilia; purpura; thrombocytopenia. *Gastrointestinal:* Nausea; epigastric distress; vomiting; anorexia; stomatitis; peculiar taste; diarrhea; parotid swelling; black tongue. Rarely hepatitis (including altered liver function and jaundice). *Endocrine:* Testicular swelling and gynecomastia in the male; breast enlargement and galactorrhea in the female; increased or decreased libido; elevated or lowered blood sugar levels. *Other:* Dizziness, weakness; fatigue; headache; weight gain or loss; increased perspiration; urinary frequency; mydriasis; drowsiness; alopecia. *Withdrawal Symptoms:* Abrupt cessation after prolonged administration may produce nausea, headache, and malaise. These are not indicative of addiction.

OVERDOSAGE: All patients suspected of having taken an overdosage should be admitted to a hospital as soon as possible. Treatment is symptomatic and supportive. However, the intravenous administration of 1–3 mg of physostigmine salicylate is reported to reverse the symptoms of tricyclic antidepressant poisoning. Because physostigmine is rapidly metabolized, the dosage of physostigmine should be repeated as required particularly if life-threatening signs such as arrhythmias, convulsions, and deep coma recur or persist after the initial dosage of physostigmine. On this basis, in severe overdosage with perphenazine-amitriptyline combinations, symptomatic treatment of central anticholinergic effects with physostigmine salicylate should be considered.

J9TR33 (DC6613215)

For more detailed information, consult your MSD Representative or see full Prescribing Information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486.

MSD
MERCK SHARP DOHME



How much is "too much" milk?

ilk, like many foods today, is being looked at much more closely than ver before by physicians and nutritionists.

And well it should be.

Because we recognize that too much milk, like too much of any one od, can fill a child up and consequently, can keep him from eating ther foods he needs. Particularly, iron-rich foods.

But let's also make sure children get enough milk. Because milk upplies more essential nutrients per calorie than most other foods.

A child between the ages of six months and six years, for example, an get at least three-fourths of his daily dietary allowance for calcium, boflavin, vitamins D and B_{12}, phosphorous, and protein from just three lasses of milk. And milk is also a good source of vitamins A and B_6, as ell as thiamin and niacin.

That's why the U.S.D.A., acting on the recommendation of the Na- onal Research Council—National Academy of Sciences, has estab- shed these guidelines for milk consumption:

Children up to 6 years
Two to three 8 oz. glasses per day.

Children 6 to 12 years
Three or more 8 oz. glasses per day.

For a free copy of the Dairy Council Digest issue titled, "Composi- on and Nutrient Value of Dairy Foods," contact your local Dairy ouncil or write the National Dairy Council, 6300 North River Road, osemont, Illinois 60018.

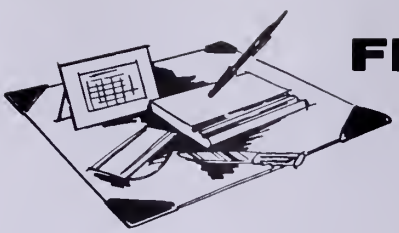
Per cent of Recommended Daily Allowance contributed by three 8 oz. glasses of fortified milk.

	6 mos.—1 yr.	1 yr.—3 yrs.	3 yrs.—6 yrs.
Calcium	100%	100%	100%
Riboflavin	100	100	100
Vitamin B_{12}	100	100	100
Protein	100	100	80
Phosphorus	100	85	85
Vitamin B_6	76	51	34
Vitamin D	75	75	75
Niacin*	71	63	47
Thiamin	56	40	31
Vitamin A	46	46	37

*maximum niacin equivalents based on: 60 mg tryptophan=1 mg niacin

ndc
National Dairy Council

Milk. Sometimes we forget all the good things it does.



FROM THE EDITOR'S DESK

APPEAL

The American Medical Association will appeal a Federal Trade Commission ruling that the "Principles of Medical Ethics" unlawfully restrict competitive advertising by physicians. Attorney Newton Minow has represented AMA since the beginning of the case four years ago. Said Minow: "To the extent that the (FTC) order continues to prevent medical societies from taking action against deceptive or other unethical practices that may harm or mislead patients, the AMA will ask the Court of Appeals to reverse the order." The FTC said nothing in its order is to prohibit AMA from "enforcing reasonable ethical guidelines governing the conduct of its members with respect to representation, including unsubstantiated representations, that would be false or deceptive . . ."

AUTHORIZATION BILL

The AMA has gone on record as supporting Sen. James A. McClure's amendment to the Federal Trade Commission Authorization Bill. The Idaho Republican's amendment would prohibit the FTC from using any funds "for the purpose of investigating, or taking any action against, or promulgating any rule or regulation with respect to any legal, dental, medical or other state regulated profession, or with respect to its state or national professional associations or its members." AMA also urged Congress to reaffirm the role of the learned professions to adopt ethical standards in the public interest.

INFLATION

The rate of increase in physicians' fees and hospital room charges continues to decline despite double-digit inflation. The Consumer Price Index for September showed increases of 1.0% in the all-items index and 1.3% for all services. However, physicians' charges were posted at 0.7% (down from August's 0.8%) and hospital charges at 0.6% (compared with 1.2% in August). Annualized rates of increase for the 12-month period ending last September were: all items, 12.1%; all services, 11.6%; hospital room charges, 11.3%; physicians' services, 9.6%.

EXCEEDS AUTHORITY

The Food and Drug Administration has been accused of exceeding its authority by trying to require patient package inserts for all prescription drugs. The AMA urged the House Subcommittee on Inter-

governmental Relations and Human Resources to conduct hearings before the FDA takes further action. Previously, AMA told FDA that the demands of consumer advocates and health providers for some drug information for patients "are not met in this overbroad and unrealistic proposal."

RELATIVE VALUE GUIDE

The American Society of Anesthesiologists says it will continue to publish and distribute its Relative Value Guide "as a service to anesthesiologists and others." The statement came in the wake of a Justice Department announcement that it will let stand a U.S. District Court ruling in the case. Last summer, the court, in New York, rejected the Government's contention that the Relative Value Guide violates the law. The government appealed to the Second Circuit Court of Appeals, but the ASA has been advised that appeal is to be dropped.

MEDICARE AMENDMENTS

The AMA has advised the House Commerce Subcommittee on Health of its position on several Medicare amendments before Congress. AMA described as necessary several amendments including provisions to strengthen PSRO confidentiality, increase outpatient psychiatric benefits, and remove the three-day hospitalization requirement for home health services. Among amendments opposed were the proposed creation of a special class of practitioner called "participating physicians" and one that would impose prevailing charge levels for each state.

VACCINE PROGRAM

HEW Secretary Patricia Harris has credited organized medicine for a reversal in the upward trend in vaccine-preventable diseases. Since the Childhood Immunization Initiative was announced in 1977, she said in a letter to the AMA, the AMA "has been in the forefront of this disease prevention campaign." Of the 24 million elementary school children assessed, 91% are protected against measles, polio and DTP, and 84% are protected against rubella.

PRISON HEALTH

The AMA has proposed the creation of a presidential commission to investigate health care of an estimated 350,000 inmates in the country' prisons and jails. H. Thomas Ballantine, Jr., M.D., Secretary of the Board of Trustees, says resources are so lacking in most penal institutions that they actually may be contributing to inmate health problems. Common deficiencies include lack of isolation wards for communicable diseases, failure to conduct physical examinations, and inadequate medical records.

The Editor

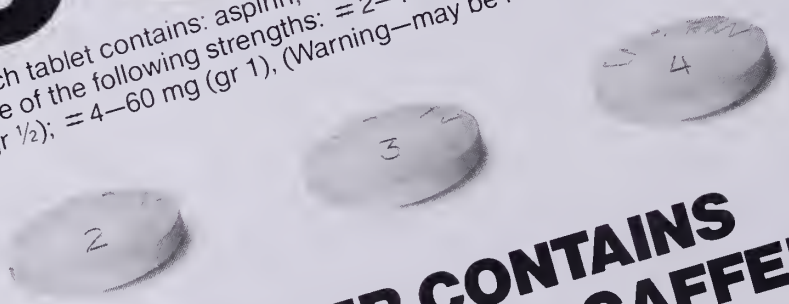
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BULLETIN FROM THE EVP'S OFFICE

FMA
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AHAROLD PARHAM, D.H.A., EXEC. VICE PRES. / DONALD C. JONES, EXEC. DIRECTOR

(The following is an abstract of a recent issue of The Gray Paper)

December 1, 1979 No. 79-6

FMA'S ANNUAL LEADERSHIP CONFERENCE IS SCHEDULED for January 26-27, 1980, at the Dutch Inn, Lake Buena Vista, Florida. The Conference will convene at 9:00 a.m. on Saturday and adjourn by noon on Sunday. Included in the program will be a legislative overview, a summary of the Department of HRS programs and activities, a report on the Florida Physician's Insurance Reciprocal, and discussion of county medical society programs and problems. Early registration is recommended.

REGULAR COMMUNICATION WITH THE LOCAL MEDIA IS VITAL according to FMA President, Richard S. Hodes, M.D., following visits to Florida's largest circulation dailies. In visiting with Editorial Boards in nine different cities earlier this month, the FMA leadership team discussed the medical malpractice liability issue, the retention of county health departments and the FMA Physical Fitness/Lifestyle program. Those representing the media were attentive, interested and engaged in meaningful dialogue on all the issues.

A NEGOTIATION TRAINING PROGRAM FOR PHYSICIANS INVOLVED IN HSA'S and similar government programs to be sponsored by FMA is being planned for early spring. The seminar is scheduled for March 21-23, 1980, in Orlando. The program will be limited to 50 participants and will be conducted by the AMA Department of Negotiations. More complete details regarding the seminar including registration information will be sent to CMS in the near future.

FLORIDA'S KEY CONTACT PHYSICIANS FOR MEMBERS OF CONGRESS worked overtime in securing favorable votes from a majority of the delegation for the Gephardt amendment to H.R. 2626 (Hospital Cost Containment Bill). The Gephardt amendment deleted the regulation provisions contained in the original version of H.R. 2626. The favorable majority vote by the Florida delegation came only as a result of personal visits by the key contact physicians including National Legislation Chairman, Louis C. Murray, M.D., working the Halls of Congress the morning of the vote.

-more-

Voting for the Gephardt amendment were:

Don Fugua (D)	Charles Bennett (D)
Bill Chappell (D)	Bill Young (R)
Andy Ireland (D)	Skip Bafalis (R)
Richard Kelly (R)	Bill Nelson (D)

Voting against the Gephardt amendment were:

Earl Hutto (D)	Dan Mica (D)
Edward Stack (D)	William Lehman (D)
Claude Pepper (D)	Dante Fascell (D)

Not voting on the bill was:
Sam Gibbons (D)

NOBEL COMMITTEE TERMS CAT SCANNER "REMARKABLE ADVANCE" in contrast to the view of federal health planners who see it only as an expensive piece of machinery and a prime target for cost cutting. In honoring the scientists who developed the CAT, with the Nobel Prize for physiology, the citation read: "It is no exaggeration to state that no other method within x-ray diagnostics within such a short period of time has led to such remarkable advances in research and in a multitude of applications." The scientists are Allan M. Cormack, a physicist at Tufts University and Godfrey N. Hounsfield, an electronic engineer at the British company, EMI.

CONFIDENTIALITY OF DCMA COMMITTEE RECORDS UPHELD. The Third District Court of Appeals recently rendered a decision upholding the confidentiality of records of the Ethics Committee of DCMA. The issue concerning the confidentiality of the Ethics Committee Records arose out of an action between parties involved in an auto accident. During the course of this litigation, the defendants served a subpoena on the DCMA asking for "any and all records" concerning the plaintiff's two treating physicians. The DCMA moved for an order prohibiting discovery of these records as privileged under Section 768.40, Florida Statutes, or as a matter of public policy. The trial court denied the motion and ordered production of the records. The DCMA petitioned the Third District Court of Appeals for certiorari and for a stay of the order of production. The Court felt that both complaints and free discussion about the activities of physicians would be markedly discouraged if their contents were to be held open to public perusal and that these considerations were largely responsible for the enactment of Section 768.40.

FOR COMPLETING MEDICAID CLAIMS, PHYSICIANS DO NOT NEED TO BUY the entire three volume set of ICD-9-CM Diagnosis Code Books. Your office only needs Volume II, Alphabetic Listing of Diagnosis Codes. To obtain a soft-bound copy of Volume II, send a check for $19.50 made payable to ICD-9-CM to: P.O. Box 991, Ann Arbor, Michigan 48106. No telephone orders are accepted. All orders must be prepaid. If you want all three volumes, send $45.50 to the same address.

THE U.S. SUPREME COURT REFUSED TO REVIEW THE MEDICAL MALPRACTICE countersuit of a Chicago area radiologist, letting stand a 1978 Appellate Court ruling that lawyers cannot be held accountable for filing suits that lack merit. Leonard Berlin, M.D., won at the trial court level in 1976 when a jury found two lawyers, their client, and her lawyer-husband guilty of "wanton and willful misconduct and negligence" for suing Dr. Berlin without probable cause and reasonable investigation. The Illinois Appellate Court reversed the decision, ruling that lawyers have no duty to their adversaries.

EXPRESS VIEW TO YOUR CONGRESSMAN. Resolution 21 introduced by the Florida Delegation and adopted by the AMA House of Delegates in July, calls on AMA to petition Congress to eliminate or drastically reduce federal funding for health planning and that it actively encourage each constituent state and county medical organization to urge its physicians to express this view to each member of Congress.

EMERGENCY RULE ENACTED DUE TO RESTRICTIVE NATURE OF AMENDMENT to the Baker Act. Because of the unduly restrictive nature of the law on its face, limiting physician participation in regard to emergency admissions under the Baker Act to those physicians who were "mental health professionals," HRS has enacted an emergency rule that defines the term "available." As this word appears in Section 394.455 (2), Florida Statutes, it means the presence or absence of mental health professionals to render service pursuant to Chapter 394, Part I, Florida Statutes. Mental health professionals are deemed not available in a county to render services when they are: not physically present within the geographic boundaries of the county; or not present in a facility where mental health services may be provided; not present at a time when mental health services are needed; or not voluntarily participating in the delivery of mental health services, under Chapter 394, Part I, Florida Statutes. In such instances, physicians, indentified in Section 394.455 (2), Florida Statutes, may: initiate emergency admissions under Section 394.463 (1) (b) 3; initiate court-ordered evaluation under Section 394.463 (2) (b) 2; and certify and testify that a patient manifests criteria for involuntary placement pursuant to the provisions of Section 394.467 (2) and (3) (a), as well as rendering all services that may be provided by a mental health professional pursuant to Chapter 394, Part I, Florida Statues, by agreement with designated receiving facilities. The emergency rule also provides for mental status examination and treatment as needed by a mental health professional within 24 hours and physical examination and treatment as needed by a physician within 24 hours when the mental health professional is not a physician.

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Unexpected expenses, Loss of income. Uncovered costs. Inflation, These, and more, can quickly add up to a severe financial burden that could take years to overcome. Unless . . . you have the foresight to help prevent such an occurrence tomorrow by enrolling in the Hospital Money Plan today.

This supplemental insurance plan — sponsored by your Florida Medical Association — has been developed to help meet the pressing financial demands you'll face when hospitalized.

In essence, the Hospital Money Plan simply provides a valuable daily benefit . . .

- up to $100 per day
- from the first day of confinement
- up to age 65 (after age 64, for one full year)
- in addition to all other insurance you may have

. . . for each and every day you are hospitalized by a covered accident or sickness.

Best of all, you and your eligible family members are *guaranteed acceptance* — regardless of your health histories! There are no questions asked, no physical exams required.

It makes sense to help provide protection for your future . . . and your family's future. For further information concerning the Plan, contact the Professional Insurance Management Company (PIMCO).

American Holistic Medical Association's

6th Scientific Program

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Sunday, March 9, 1980 **HYPERTENSION SEMINAR.** *Chairman:* John H. Laragh, MD, Cornell Medical Center, New York. *Speakers:* John H. Laragh, MD (New York); Frank A. Finnerty, Jr., MD (Washington, D.C.); Ray W. Gifford, Jr., MD (Cleveland); Francesco del Greco, MD (Chicago); Thomas A. Kieth,III, MD (Cincinnati); David T. Lowenthal, MD (Philadelphia); Colman Ryan, MD (San Francisco); and Robert C. Tarazi, MD (Cleveland).

Monday, March 10, 1980 **WHAT'S NEW IN MEDICINE? SEMINAR.** *Chairman:* Michael E. DeBakey, MD Baylor College of Medicine, Houston. *Speakers:* Michael E. DeBakey, MD (Houston); Marco Caine, MD (Jerusalem, Israel); Frank H. DeLand, MD (Lexington, Ky.); Bernard F. Germain, MD (Tampa); David L. Horwitz, MD (Chicago); Ruth Jackson, MD (Dallas); Leon O. Jacobson, MD (Chicago); Alfred S. Ketcham, MD (Miami); George R. Prout, Jr., MD (Boston); Ronald J. Scott, MD (Fort Lauderdale); James I. Tennenbaum, MD (Columbus, OH.); C. Craig Tisher, MD (Durham); and Harrison D. Willcutts, MD (West Springfield, MA.).

Tuesday, March 11, 1980 **DIGESTIVE DISEASES SEMINAR.** *Chairman:* Arvey I. Rogers, MD, University of Miami. *Speakers:* Arvey I. Rogers, MD (Miami); Martin Kalser, MD (Miami); Joe U. Levi, MD (Miami); Eugene Schiff, MD (Miami); Leon Schiff, MD (Miami); and Elliot Weser, MD (San Antonio).

Wednesday, March 12, 1980 **CANCER SEMINAR.** *Chairman:* R. Lee Clark, MD (University of Texas System Cancer Center, Houston. *Speakers:* R. Lee Clark, MD (Houston); Roy Ashikari, MD (New York); Hugh R.K. Barber, MD (New York); Albert Bothe, Jr., MD (Boston); Frank H. DeLand, MD (Lexington, KY.); Philip R. Exelby, MD (New York); Victor Fazio, MD (Cleveland); Alfred S. Ketcham, MD (Miami); Gerald P. Murphy, MD (Buffalo); George R. Prout, Jr., MD (Boston); and Charles L. Vogel, MD (Miami).

Thursday, March 13, 1980 **UROLOGY SEMINAR.** *Chairman:* George R. Prout, Jr., MD, Harvard Medical School, Boston. *Speakers:* George R. Prout, Jr., MD (Boston); Marco Caine, MD (Jerusalem, Israel); Robert Krane, MD (Boston); Edwin M. Meares, Jr., MD (Boston); Frederick K. Merkel, MD (Chicago); Gerald P. Murphy, MD (Buffalo); Thomas J. Rohner, Jr., MD (Hershey, PA.): and Robert H. Rubin, MD (Boston).

Friday, March 14, 1980 **NUTRITION/HYPERALIMENTATION SEMINAR.** *Chairman:* George L. Blackburn, MD, PhD, Harvard Medical School, Boston. *Speakers:* George L. Blackburn, MD, PhD (Boston); Bruce R. Bistrian, MD, PhD (Boston); Johan Bjorksten, PhD (Madison, WI.); Albert Bothe, MD (Boston); David L. Horwitz, MD, PhD (Chicago); Herbert P. Sarett, PhD (Evansville, IN); Philip L. White, ScD (Chicago); Harrison D. Willcutts, MD (West Springfield, MA.).

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Defibrination Syndrome Following Bites by the Eastern Diamondback Rattlesnake

L. H. S. Van Mierop, M.D. and Craig S. Kitchens, M.D.

Abstract: Six cases of bites by Eastern diamondback rattlesnakes are described. In four young men envenomation was mild; in a 10-year-old boy it was moderate. The sixth patient, a young woman, was more severely envenomated. Defibrination syndrome developed within eight hours after the accident in all cases and persisted for ten to 43 hours. There was a slight to moderate fall in the platelet count in five cases. None of the four mildly envenomated patients showed evidence of spontaneous bleeding which supports the view that the defibrination induced by pit viper venom in itself is a benign state and is not necessarily an indication for treatment with antivenin. Nonetheless, we recommend that clotting studies, even if initially normal, be repeated at 3-4 hour intervals for the first 12 hours after the bite has occurred in every patient who has been bitten by an unidentified pit viper or by a pit viper whose venom is known to be able to produce defibrination, even if the case appears to be mild or even trivial. Should defibrination occur, the patient should remain hospitalized until the coagulopathy has reversed itself.

Defibrination syndrome may follow bites by pit vipers **(Crotalinae)**, true vipers **(Viperinae)** and some species of elapid and colubrid snakes and is due to a procoagulant in the venom. Venom of the Eastern diamondback rattlesnake **(Crotalus adamanteus)**, in common with that of many other pit vipers, has thrombin-like activity which produces a consumption coagulopathy. Defibrination after severe bites inflicted by this species of snake has been reported.[1-3]

We recently had the opportunity to observe six patients bitten by Eastern diamondback rattlesnakes. Defibrination syndrome developed in all, even though in four cases the bite was rather trivial. These cases attest to the potency of the procoagulant fraction present in the venom of the Eastern diamondback rattlesnake and illustrate the dilemma one may be faced with in the management of such cases.

From the Departments of Pediatrics (Cardiology, Dr. Van Mierop) and Medicine (Hematology, Dr. Kitchens), University of Florida College of Medicine, Gainesville.

Case Reports

Case 1. — A 25-year-old man was bitten in the left middle finger by a three foot long Eastern diamondback rattlesnake. Incision and suction were not done. The patient arrived in excellent condition in the Emergency Room (ER) approximately one hour after the bite. Vital signs were normal. Physical examination was unremarkable except for minimal perioral fasciculations. There was a single fang mark on the ulnar aspect of the middle phalanx of the left middle finger (Fig. 1A) with marked swelling of that finger and the dorsum of the hand to just above the wrist. Skin testing with normal horse serum (Wyeth) was mildly positive and no antivenin was given. Initial prothrombin time (PT), partial thromboplastin time (PTT) and thrombin time (TT) were normal. Eight hours after the bite had occurred, however, the blood had become unclottable and remained so for 12 hours (Fig. 2A). There was a slight fall in the platelet count to a minimum of 177,000/mm^3, still within normal range (Fig. 2B).

The hospital course was unremarkable. By the second hospital day the swelling of the hand had begun to decrease and the patient was discharged on the fourth day.

Case 2. — A 25-year-old man was bitten in the right heel by a rattlesnake about one hour prior to arrival at the ER. He had numbness around the mouth and some tingling of the fingers. The past history was unremarkable. Vital signs were normal, and physical examination was

unremarkable except for perioral fasciculations. A single barely visible fang mark surrounded by minimal swelling was present over the right Achilles tendon. (Fig. 1B) The platelet count and clotting studies were normal. The case was judged to be very mild and no antivenin was given.

The blood was unclottable 4½ hours post-bite (Fig. 2A). At 15 hours there were fasciculations of the lower leg over a limited area in the region of the soleus muscle and also the medial aspect of the foot. The swelling extended to above the ankle. The dorsum of the foot was mildly edematous. There was no evidence of necrosis or vascular embarrassment. Thirty-two hours post-bite only the TT was prolonged. The platelet count fell to a minimum of 85,000/mm^3 (Fig. 2B). By the third hospital day, the fasciculations of the leg had disappeared and the swelling had decreased. The patient was discharged on the fourth hospital day.

Case 3. — A 10-year-old boy was bitten twice on the right great toe by a juvenile Eastern diamondback rattlesnake. Skin testing with horse serum resulted in a wheal measuring 4 cm and antivenin was not administered. The boy was transferred to the Shands Teaching Hospital where he arrived about 2½ hours after the bite. Vital signs were normal and the physical examination was unremarkable except for the presence of perioral fasciculations. There were at least three fang marks on the dorsum of the foot near the base of the first and second toes. Ecchymoses and swelling extended proximally over the dorsomedial aspect of the foot. Clotting studies done on admission were normal. The patient vomited shortly after admission and again the next morning. He had several loose stools which were guaiac positive.

Seven hours post-bite fasciculations involved the shoulders. The patient complained of abdominal pain and the temperature was 38.6 C. The blood had become unclottable (Fig. 2A). The platelet count however was normal and remained so (Fig. 2B). Of interest is that the patient's blood type could not be assessed. The hospital course was uneventful. Fasciculations disappeared by 24 hours post-bite and the clotting studies returned to normal in 48 hours. The boy was discharged on the fourth hospital day.

Case 4. — A 26-year-old man was bitten in the left hand by a juvenile Eastern diamondback rattlesnake. No tourniquet was used and incisions were not made. Twenty-five minutes after the bite, the patient began to notice tingling around the mouth associated with muscular twitching and felt numbness of the hands and feet. The patient was transferred to the Shands Teaching Hospital where he arrived 2½ hours after he had been bitten. The vital signs were normal and the patient's general condition was good. Fasciculations of the tongue, mouth and left thenar musculature were observed. There were two tiny fang marks 5 mm apart in the presence of moderate swelling on the medial aspect of the base of the proximal phalanx of the left index finger (Fig. 1C). There was some bluish discoloration of the thenar region. The dorsum of the hand was swollen to the wrist. There was no evidence of vascular embarrassment. No antivenin was given. TT and PTT done three hours post-bite were $>$ 60 seconds (Fig. 2A). Fasciculations of the tongue and the mouth had disappeared by 16 hours post-bite. By 42 hours post-bite, the clotting studies had returned to normal and the patient was discharged on the third hospital day.

Case 5. — A 19-year-old college student was bitten in the right index finger by a small snake initially believed to be a pigmy rattlesnake. A tourniquet had been placed around the finger which was released for about 30 seconds every five minutes. He was seen at a local hospital about 25 minutes after the accident. The vital signs were normal. The single fang mark had not been incised but suction was continued. The patient was transferred to the Shands Teaching Hospital where he arrived 1½ hours post-bite. The tourniquet was removed. The only symptoms on arrival were pain in the right index finger and tingling of the hands, feet and mouth. The finger was minimally discolored with moderate swelling (Fig. 1D). Circulation in the finger was excellent. Faint fasciculations of the tongue and the right hand were noted. The remainder of the physical examination was unremarkable. No antivenin was given. Initial PT and PTT were normal but the TT was slightly prolonged (Fig. 2A). Seven hours after the bite the blood had become unclottable. Clotting studies had returned to normal 24 hours after the bite. The platelet count remained normal (Fig. 2B).

Case 6. — A 32-year-old very obese woman was bitten twice in the right foot by a 3½ to 4 foot rattlesnake. A soft rubber tourniquet was loosely applied around the lower leg and the patient was transferred to the Shands Teaching Hospital ER. She was anxious but alert and in good condition. The skin test was negative. On initial examination there were obvious fasciculations of the face, hands and feet. There were two sets of fang marks on the medial aspect of the right foot between the heel and the ankle. There was no discoloration or ecchymoses and remarkably little swelling. The remainder of the physical examination was unremarkable. The tourniquet was removed. Over the next hours the fasciculations became generalized, yet the local symptoms remained unimpressive.

Blood samples were obtained for clotting studies and platelet count less than two hours after the bite had occurred, however, the samples appeared to have clotted and were discarded. A second set drawn 1½ hours later demonstrated a severe coagulopathy (Fig. 3) but a platelet count could not be done because the sample was again judged to have clotted. Five hours post-bite the count was 125,000 mm^3. The hematocrit (Hct) was 51%.

At ten hours there had been a slight increase in circumference of ankle and calf. Fasciculations continued. Seven hours later the swelling of the leg had extended up to the knee. The platelet count obtained eight hours post-bite was 30,000/mm^3 but was inadvertently not reported until seven hours later. A repeat count was 52,000 mm^3. Because the platelet count was increasing, it was decided not to give antivenin. The Hct had not changed. Forty-five hours after the bite the TT was still slightly elevated but the PT and PTT had returned to normal. The platelet count was 170,000/mm^3. Swelling and ecchymoses of the right leg increased (Fig. 1E, F) and extended into the groin. Five hours later all clotting studies returned to normal; by five hours thereafter (55 hours post-bite) however the Hct had fallen to 41% (Fig. 3). By the end of the third day the swelling of the leg decreased, and the patient was discharged on the fifth hospital day.

Discussion

Procoagulant amino acid esterases present in many viper and pit viper venoms induce intravascular clotting either by direct action on fibrinogen or by activation of factor X.[4-9] Activation of factor X is typical of Viperid venoms (e.g. Russell's viper venom, the prototype of this mechanism) while direct cleavage of fibrinogen is almost restricted to Crotalid venoms. Some of the latter venoms have both types of action but the direct effect on fibrinogen is usually dominant.

Although thrombin-like snake venom procoagulants hydrolyse fibrinogen, as does thrombin, there are important differences between the action of these enzymes and thrombin. These differences account for the dissimilarities between the defibrination syndrome due to snake bite envenomation and typical, thrombin generated disseminated intravascular coagulation (DIC) which occurs as a complication of overwhelming gram-negative endotoxemia and many other disease states. Thrombin cleaves fibrinopeptide A from the *a* chain of

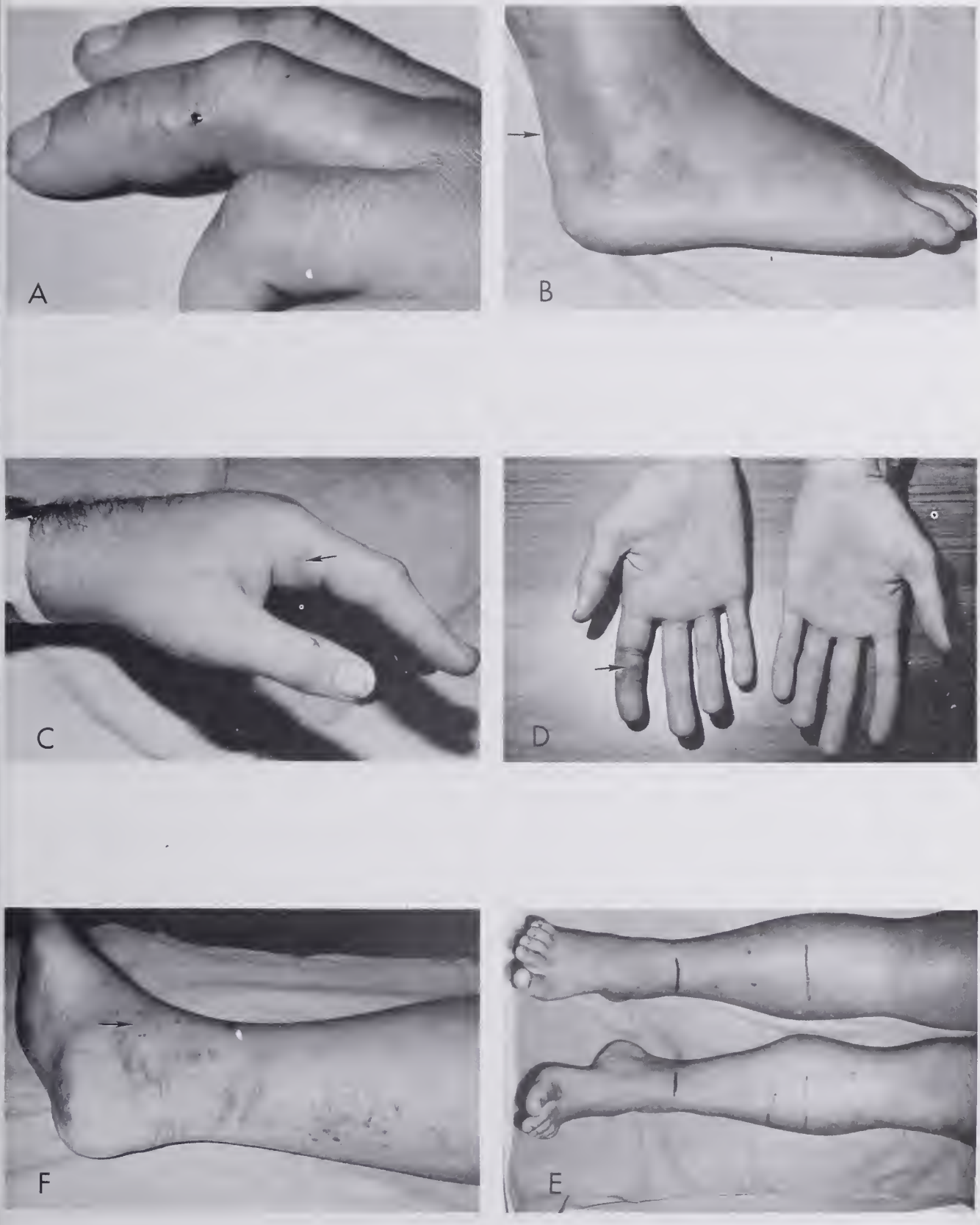


Fig. 1. — Maximal manifestations of local injury in A: Case 1, B: Case 2, C: Case 4, D: Case 5, E, F: Case 6. Arrows indicate localization of fank mark(s), often hard to see after the first day or two.

fibrinogen and fibrinopeptide B from the β chain of fibrinogen. This results in fibrin monomers which readily aggregate into a fibrin network. As thrombin activates factor XIII (fibrin stabilizing factor), the fibrin network is rapidly converted into a covalently cross-linked, plasmin-resistant clot. Both factor VIII and platelets are avidly consumed. Many crotalid venom procoagulants, on the other hand, appear to cleave only fibrinopeptide A and an imperfect clot is produced. Since factor XIII is not activated, the poorly formed and unstable clot is rapidly lysed by the endogenous plasminogen-plasmin system resulting in high titers of fibrin degradation product (FDP) and a state of "pure" defibrination, sometimes as early as 30 minutes after the victim has been bitten.[10] Furthermore, factor VIII and platelets are not "consumed" and a characteristic DIC picture is not produced.

Venom procoagulant esterases with thrombin-like action differ from thrombin also in that they are not inhibited by heparin. They may or may not cause platelet aggregation and thrombocytopenia may be mild or absent. Curiously, the ability of the venom to aggregate platelets and the occurrence of significant thrombocytopenia are not always correlated. Reid et al[11] reported thrombocytopenia as occurring regularly after bites by the Malayan pit viper even though the venom of that snake does not aggregate platelets in vitro. Weiss et al[3] reported a patient envenomated by an Eastern diamondback rattlesnake whose platelet count was not affected and related this to the inability of the venom to aggregate platelets. Others,[1,2] however, have observed mild to moderate thrombocytopenia after Eastern diamondback rattlesnake bites.

Continued defibrination following pit viper bites is readily abated by antivenin administration, usually within hours.[9,10,13] Blood transfusions, fibrinogen infusions, heparin and ε-amino caproic acid, used in the treatment of other defibrination syndromes, have proved disappointing and should not be used.

Venom-induced defibrination by itself does not lead to extensive hemorrhage[10,12,13] and in this respect the clinical features resemble those seen in congenital afibrinogenemia. It does, however, aggravate hemorrhage due to trauma or other mechanisms, including that produced by the very potent cytolytic toxins ("hemorrhagins") present in many snake venoms. These hemorrhagins, in conjunction with venom procoagulants, may, in severe cases, produce a potentially dangerous hemorrhagic syndrome which can cause serious and life-endangering bleeding.[11]

The benign nature of the hypofibrinogenemic state after pit viper and viper bites has been repeatedly commented upon.[5,9,10-12,14] Patients may have unclottable blood for days or weeks yet they are asymptomatic and perfectly well otherwise. In one report of five pregnant women bitten by Malayan pit vipers, only one aborted and that without excessive blood loss.[10] Another woman with uncoagulable blood had normal menstrual blood loss. All six women were severely envenomated. Reid[14] commented "there must be countless folk pursuing normal activities unaware that they are defibrinated."

The venoms of four of the five pit vipers indigenous to Florida contain procoagulant esterases. That of the cottonmouth **(Agkistrodon piscivorus),** however, cleaves only fibrinopeptide B which is inadequate to

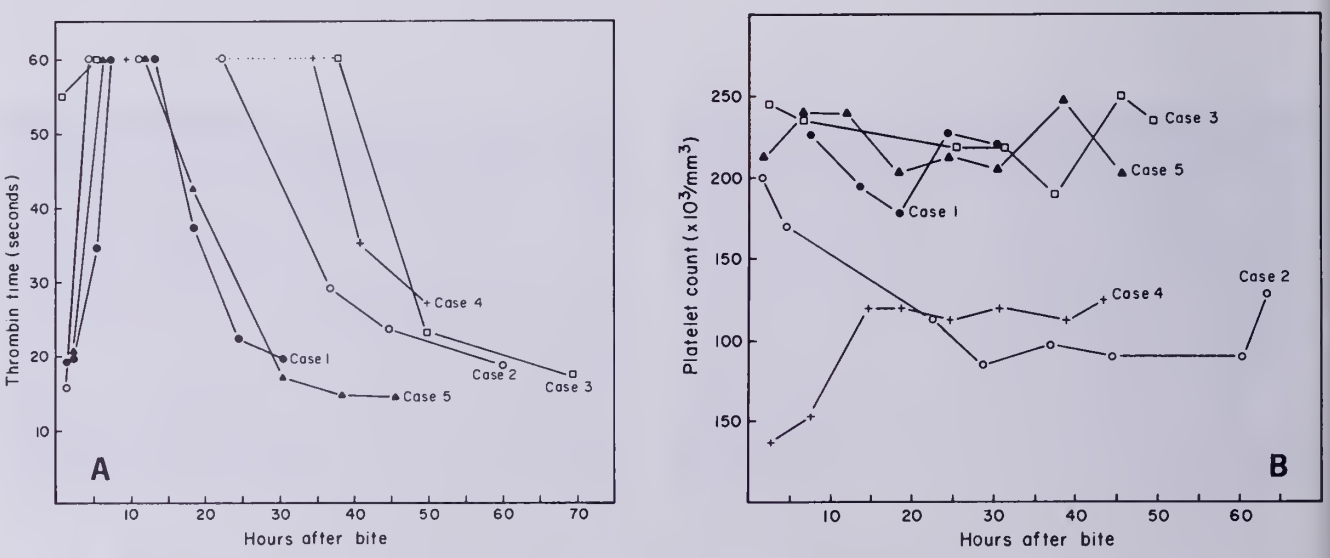


Fig. 2. — Thrombin times and platelet counts in five patients (cases 1-5) following mild bites by Eastern diamondback rattlesnakes.

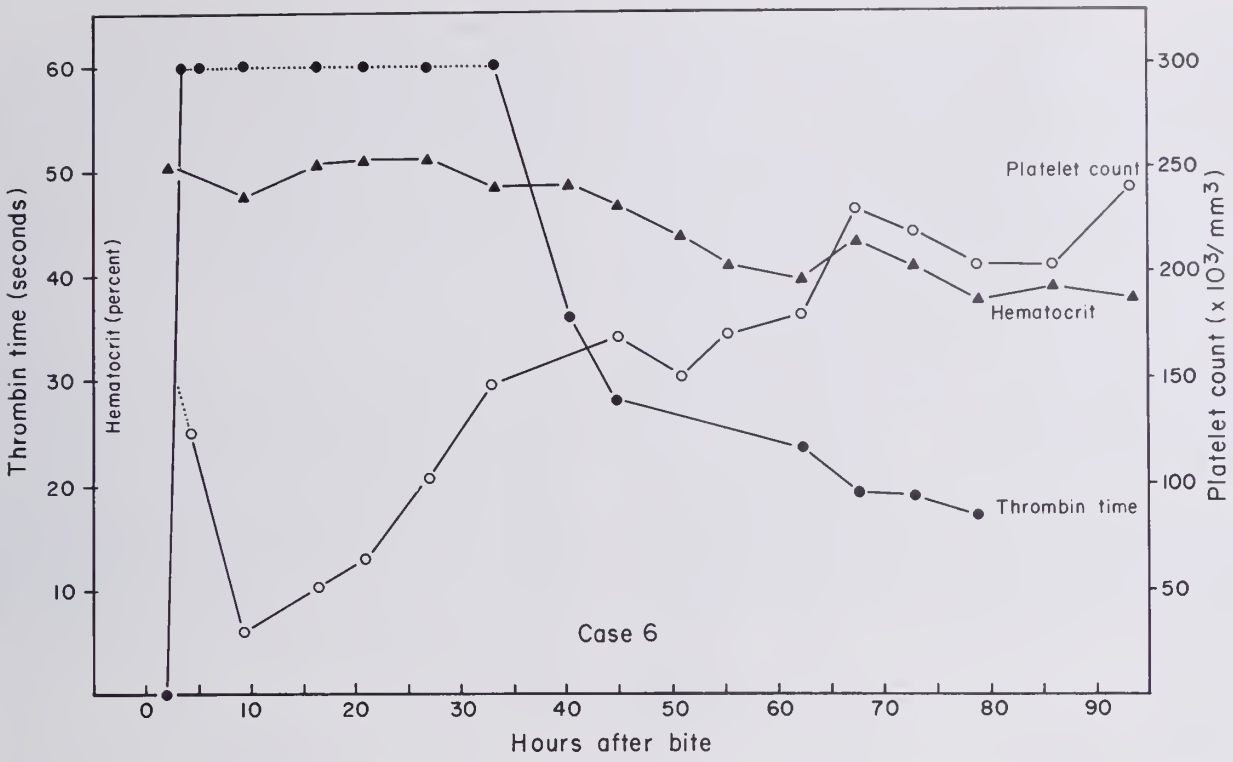


Fig. 3. — Hematocrits, thrombin times and platelet counts of patient 6, a case with moderately severe envenomation.

produce clotting[15] while the venom of the Southern copperhead **(A. c. contortrix)** cleaves fibrinopeptide B much faster than fibrinopeptide A.[16] The bites of these two snakes therefore do not produce defibrination. Venom of the other two species, the canebrake rattlesnake **(C. horridus atricaudotus)** and the Eastern diamondback rattlesnake, contain esterases which cleave fibrinopeptide A. The Eastern diamondback rattlesnake is much the more important since it is quite common and occurs throughout the state while the former is limited to the Panhandle and the extreme northern part of peninsular Florida.

Crotalase, the procoagulant enzyme from the venom of the Eastern diamondback rattlesnake, has been purified and its properties have been studied in vitro and in vivo.[11,17-19] Its actions are very similar to that of other pit viper venom esterases with thrombin-like activity. Crotalase is rapidly excreted or inactivated. At high concentrations, crotalase is weakly fibrinolytic.

It is not generally appreciated that a profound coagulation defect may result from snakebite in cases otherwise adjudged to be mild, or even trivial, using traditional clinical "grading" criteria. Incoaguable blood obviously complicates the management of such cases. Defibrination may not manifest itself for several hours, and coagulation studies should be repeated if the offending snake is known to have been a pit viper whose venom has the ability to produce the syndrome. Victims who have any evidence of envenomation, no matter how trivial this appears to be, should not, in our opinion, be discharged from observation until it has been ascertained that clotting studies have remained normal for at least 12 hours after the bite has occurred. Any major vessel bleeding in a defibrinated individual, e.g. from a peptic ulcer or injury, obviously could have serious consequences.

The difficulty in typing the blood of an envenomated patient has been previously observed.[20-21] The red cells of such a patient clump in vitro, an effect likely due to products of the defibrination. Blood typing, therefore, should be done as early as possible after the bite has occurred.

The in vitro "clotting" of the initial blood samples in patient 6 is of interest. We believe it was induced by partial gelling of plasma by the procoagulant action of the venom. There were no in vivo correlations except for the transient thrombocytopenia which perhaps was due to passive microcirculatory trapping of the platelets.

We believe that case 6 should have received antivenin, but should our first five patients have also? The presence of fasciculations and unclottable blood demonstrated that venom had entered the general

circulation and antivenin therapy is generally said to be indicated if there is evidence of systemic envenomation. Nevertheless, we elected not to administer antivenin. In the two patients having a positive skin test (cases 1 and 3), we believed that the risk of serotherapy outweighed its potential benefits. The other three patients were healthy, young individuals without a history of any condition which might cause bleeding. The local symptoms were trivial, the platelet counts remained quite adequate and there was no evidence of a hemorrhagic syndrome. We did not believe that the defibrination syndrome, by itself, presented a particular hazard as long as the patient remained hospitalized and could be closely observed.

We certainly agree that antivenin is highly effective in the treatment of systemic symptoms due to snakebite envenomation and are strong proponents of its use when indicated. We also feel however that it should not be given indiscriminately or according to any rigid set of rules and do not believe that antivenin therapy is mandatory simply because there are systemic symptoms, as long as such symptoms do not reflect a condition or conditions which by themselves are likely to endanger the patient.

As antivenin is prepared from horse serum, it is strongly antigenic and can and usually does cause hypersensitivity reactions. Even though most modern preparations are more refined and concentrated than previously, they cannot be considered innocuous drugs and should not be indiscriminately used. Anaphylaxis, the most severe and dangerous form of hypersensitivity reaction, is fortunately uncommon and rarely causes death; less severe and delayed reactions (serum sickness) on the other hand are very common.[20,22,23] Neither the incidence nor the severity of serum sickness correlates well with the amount of antivenin given.[22,24] Unexpected anaphylactoid reactions have been observed in patients who had negative sensitivity tests and had had no previous exposure to equine proteins.[13,23-25]

Such unexpected reactions all appear to have occurred in patients who were being treated for snakebite envenomation. This may be because antivenin is generally given intravenously, often rather rapidly, and in quantities much greater than other biological preparations, e.g. tetanus antitoxin. Sutherland[26] has found strong presumptive evidence that unexpected, de novo reactions are related to anticomplimentary activity present in most commercially prepared antivenins and antitoxins and recommends that antivenin be infused slowly and in diluted form.

The number of patients described in this study is small and more observations are obviously needed. We feel justified, on the basis of our own experience and the clinical and laboratory data published by others concerning snake venom-induced defibrination, to suggest the following guidelines as to management of patients with mild bites by the Eastern diamondback rattlesnake: (1) Coagulation studies should be done whenever a victim shows evidence of envenomation, no matter how trivial this may appear to be. (2) Any patient who has evidence of defibrination should remain in the hospital until the coagulopathy has reversed (a normalization of the thrombin time) and, if present, thrombocytopenia has begun to abate. (3) Perioral and local fasciculations as the only sign of systemic envenomation, in general, should not be an indication for the use of antivenin. (4) Defibrination, per se, is not necessarily an indication for antivenin therapy in mild cases provided the patient is young, e.g. less than 45 years of age, in good health, has a platelet count greater than 50,000 mm^3, has no history of any condition that could cause major vessel bleeding, and has no evidence of venom-induced hemorrhagic syndrome such as ecchymoses, discoid hematomas, bleeding gums, or blood in the sputum, urine or stool.

Addendum

After the manuscript had gone to press, the following case was related to us by Dr. James G. White of Ormond Beach, Florida, who kindly allowed us to publish it.

A 4½-year-old girl was bitten on the right foot by a juvenile Eastern diamondback rattlesnake. She was seen at Halifax Hospital some two hours after the bite at which time two fang marks were noted on the dorsomedial aspect of the foot. There was a moderate amount of swelling and some bluish discoloration of the dorsum of the foot. There were no fasciculations or any other evidence of systemic envenomation. Her vital signs were normal.

When contacted by Dr. White concerning this patient, we suggested, in view of our recent observations, that clotting studies be done even though the case appeared to be a very mild one. These studies, drawn about three hours after the bite, turned out to be grossly abnormal indicating a state of defibrination. Bleeding was also noted from puncture wounds. The platelet count was normal and remained so on subsequent examinations. Clotting studies returned to normal within hours after intravenous administration of seven vials of antivenin. The subsequent hospital course was uneventful.

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Use of a Primary Care Clinic by Residents of a Rural Florida County

Lee A. Crandall, Ph.D.

Abstract: An analysis of patient encounters, population estimates and national norms can provide useful data on health care utilization in rural communities when household survey data are unavailable. Data from Lafayette County, Florida are examined for age, race, and sex differences in the use of a rural primary care clinic. The analysis suggests that black children receive fewer services than white children but that among adults blacks use clinic services at nearly the rate expected based on national norms for rural residents. Actual use of clinic services by whites is lower than the expected rate. However, middle class whites may be more likely to use services of private physicians. Data from this study enabled the primary care clinic to target programs at two groups shown to be low users of services: the low income elderly and black children.

In the past 15 years a number of government programs have attempted to influence the delivery of health care in rural communities by altering the distribution of health manpower and the way in which health care is purchased. Although these programs differ in approach and in their effectiveness, they share the underlying premise that all individuals and communities should have equal access to health care. According to this viewpoint the physician's traditional responsibility to provide the best possible health care for each individual patient must be complemented by a concern for the community as a whole and especially for those members of the community who currently fail to receive adequate health care.

However, data needed to identify individuals and groups with restricted access to a community's health care system are difficult to obtain. Data from government reports are often too highly aggregated to be of use for this purpose. Physicians and health departments usually can gather data only on those persons who have received medical care and are unable to specify with certainty the portion of the total community which they serve. There exists no master file of potential patients comparable to the British general practitioner's "list" which can be used to generate accurate statistics on utilization rates in the population.

One solution to this dilemma has been the application of sample survey methods to questions of health services use. Household health surveys generally provide valuable information on utilization patterns and have been extremely helpful in documenting sociodemographic differences in the availability and use of health services. Several decades of experience demonstrate that these surveys provide accurate descriptions of utilization patterns.[1-5] However, costs involved in implementing household surveys are substantial and they require short-term time commitments from large numbers of well-trained researchers. It is usually impractical to conduct a household health survey in small rural communities unless substantial financial support is available from an outside agency. Therefore most small communities must attempt to address issues of access to care by making the best possible use of published data available from decennial censuses, health care providers, health systems agencies and other sources of health and socioeconomic data. This paper uses data available for one rural county to describe demographic differences in the use of health care at a rural primary care clinic.

Study Background

Lafayette County, Florida (population 3,277) is in the north-central portion of the Florida peninsula. The median income of families was $4,590 in 1970 with nearly one third of the population below poverty level. The only health care available in the county is provided by the Lafayette County Health Center in Mayo, the county seat. This clinic combines primary care services with

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services of the county health department and also serves as a site for state Childrens Medical Services programs. The clinic's physicians include faculty and housestaff assigned by the Department of Community Health and Family Medicine of the University of Florida College of Medicine. Previously published articles describe the clinic in greater detail.[6,7] Lafayette County has no private practicing physicians and alternative sources of primary care in adjacent counties require a minimum 50-60 mile round trip. The Lafayette County Health Center's records show that it has provided services on at least one occasion for virtually every resident of the county. In fact, a large number of patients from adjacent counties have begun to use this clinic as a source of routine care. Recently the clinic staff recognized a need for more detailed information on their role in meeting Lafayette County's health care needs. Since a household health survey was not feasible, an analysis of extant data was conducted. Data employed in this study include age-sex-race specific tabulations of unduplicated users and encounters for the year 1976, age, sex, race specific population estimated for Lafayette County in 1976,[8] and national estimates of utilization drawn from the publications of the National Center for Health Statistics.[9,11]

Utilization data were drawn from the Department of Community Health and Family Medicine's computerized Health Information System. While use of the computer made it possible to assemble rapidly the data on utilization, similar data are often produced through hand tabulation by rural clinics participating in federal programs administered by the Bureau of Community Health Services as a part of that Bureau's reporting requirements. The study described here does not require the use of a computer and could be replicated in any county which has a single provider (e.g. rural health center, solo physician or group practice) that serves as the major ambulatory care resource for the county's population.

Table 1. — Number of Residents of Lafayette County and Number and Percent Using Clinic Services One or More Times by Age Category, Sex and Race.

	Number of Residents in County	Number of County Residents Using Services	Percent of County Residents Using Services
Female			
Black:			
0-14	57	28	49
15-44	80	62	78
45-64	23	16	70
65+	10	9	90
	170	115	68
White:			
0-14	347	255	73
15-44	553	331	60
45-64	337	132	39
65+	261	100	26
	1,498	818	55
Total Females	1,668	933	56
Male			
Black:			
0-14	70	41	59
15-44	65	34	52
45-64	19	13	68
65+	14	9	64
	168	97	57
White:			
0-14	377	281	75
15-44	570	319	56
45-64	300	115	38
65+	194	104	54
	1,441	819	57
Total Males	1,609	916	57
Total Population	3,277	1,849	56

Findings

Data for 1976 show that the Lafayette County Health Center provided 8,207 patient encounters for 3,322 separate patients. However, this paper reports data only for the 1,845 (55.5%) of these patients who were Lafayette County residents. Table 1 compares the number of people in specified categories of the county's population with the number of county residents who used the services of the clinic one or more times during 1976. Overall, 56% of the county's population used services at least once during that year, however the proportion using these services varied by age, sex and race.

The majority of county residents under the age of 15 were served by the clinic at least once during 1976, but white children were more likely to have been served than black children. Only 49% of black females under 15 years of age and 59% of black males at that age group used clinic services in 1976 while about three fourths of white children used the clinic's services.

A high proportion of females in the child-bearing years (15-44) used the clinic during 1976 and in this category black residents were more likely to have been served than white residents. Males in the 15-44 age group were less likely to have used clinic services than females. No substantial difference between races existed for these males.

Table 2. — Expected Number of Visits, Actual Number of Visits and Actual Visits as a Percent of Expected Visits by Age Category, Sex and Race, Lafayette County, 1976.

	Expected Number of Visits	Actual Number of Visits	Actual Visits as Percent of Expected
Female			
Black			
0-14	108	81	75
15-44	224	188	84
45-64	74	58	78
65+	45	40	89
	451	367	81
White			
0-14	659	638	97
15-44	1,548	767	50
45-64	1,078	465	23
65+	1,175	395	33
	4,460	2,265	51
Total Females	4,911	2,632	54
Male			
Black			
0-14	154	99	64
15-44	104	83	80
45-64	48	61	127
65+	50	60	120
	356	303	85
White			
0-14	829	742	90
14-44	912	690	76
45-64	750	323	43
65+	698	403	58
	3,189	2,158	68
Total Males	3,545	2,461	69
Total Population	8,456	5,093	60

For ages over 45, white residents of the county were less likely to have used clinic services than black residents. This difference was especially marked for females over age 65 where only 26% of whites but 90% of blacks visited the clinic in 1976.

Rates of utilization of primary care vary for men and women according to age. Therefore, this study also examined the actual number of encounters provided for different demographic groups in 1976 and compared this measure of use with estimates of expected use. The most recent national data on age-sex specific rates of physician visits per year for nonmetropolitan areas available in sufficient detail were from the 1973-74 National Ambulatory Medical Care Survey. These rates were employed as a measure of expected use. Age-sex-race components of the Lafayette County population were multiplied by these national rates in order to estimate the expected number of annual visits which would apply to each population component.

Table 2 compares these expected values with the actual use of the clinic. Patterns of use seem quite similar to those displayed in Table 1 although demographic differences are accentuated. White children receive nearly all of the visits expected from national norms, while use among black children is substantially lower. Black adults, especially males, appear to receive nearly all of their expected annual physician visits at the Lafayette County Health Center while white adults, especially females and the elderly, receive considerably fewer than the expected number of annual visits. One exception is in the category, male: 15-44 where no substantial difference in use between black and whites exists, and clinic use accounts for roughly three fourths of expected visits.

Discussion

Without a sample survey or some other type of primary data collection effort addressed to the issue of health care utilization in Lafayette County it is impossible to validate the findings presented here. However, these findings appear to fit with perceptions of health care providers in the clinic and correspond well with findings from household interview surveys conducted elsewhere in the rural South. Blacks appear to be higher users of clinic services than whites, perhaps because of lower access to other sources of care. However, black children are less likely than white children to have used the various services provided at the Health Center during the past year. These data strongly suggest that black children may not be receiving as much health care as white children. It is unlikely that black children not seen by any of the agencies serving the Lafayette County Health Center in 1976 received significant amounts of care from providers in other counties. These children's families have lower incomes and less access to transportation than those of white children and are often unaccustomed to seeking preventive health care.

No information is available from this study to address the issue of use of out-of-county health services by Lafayette County residents. However, it seems likely that many adult whites make use of health services in outlying counties while most adult blacks rely almost exclusively on the clinic for their health care. Knowledge of the community suggests that adult whites have access

to private practicing physicians in surrounding communities with whom they have long standing doctor-patient relationships. This source of care may not be equally available for children and teenagers or for many blacks or elderly whites with low incomes. Salber and associates[12] report that low income rural elderly whites were particularly underserved in a rural North Carolina community where they conducted a household health survey and the data reported in Table 2 suggest that this may be equally true in Lafayette County.

Conclusion

While less definitive than a household health survey, the analysis presented here provides information which may be useful in improving health services in Lafayette County. The data show that much of the clinic population is drawn from outside the county. Data on clinic use by Lafayette County residents show that black adults residing in the county use the clinic for the major portion of the health care which rural adults would be expected to receive based on national norms. The study suggests that health services for black children and low income elderly whites require special attention.

The Lafayette County Health Center plans to target special programs of patient education, information and service at children during the coming years. Plans are underway for a health census of black children in the community to be conducted by nursing students and the Health Center now audits all charts of pediatric patients in order to assure that necessary preventive care is being delivered. Health needs of low income elderly in Lafayette County are being addressed by expansion of home health services and increased attention to geriatric care.

Examination of clinic use in Lafayette County shows that, despite the paucity of household health survey data which usually exists, community health efforts in rural communities can be focused more accurately on the health problems of underserved demographic groups if existing data on pupulation characteristics and health care currently used by the community are assembled and analyzed.

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Changing Times

"Ignorance accounts for many evils, and should be informed by knowledge, but knowledge accounts for many evils and must be directed by intelligence, but intelligence accounts for many evils and must be guided by wisdom, but wisdom is a component of character as much of mind, which accounts for the rarity of right action even among the educated and the intelligent."

As the old year ends, bleak is the future when viewed alongside our used up resources, our polluted environment, the staggering burdens laid on our government, the battering of the family, the erosion of work, the imperial ego, the ethics of anything-goes, the refusal to see anything in life as sacred, the loosening of individual morals, the world's ever growing population, inflation, hunger and the threat of nuclear destruction.

Times such as these have always bred defeatism and despair, nevertheless, man has within him the capacity to meet and overcome even the greatest challenges. Moral responsibility is not to stop, or dodge, the future, but to shape it, to channel man's destiny in humane directions and ease the trauma of transition.

By the time a child, born this new year, leaves college, the amount of knowledge will have quadrupled so that continuing education will be a requirement for all walks of life in the rapidly approaching next century. Even in the new year the rewriting of textbooks will be an ever recurring event, as 10 per cent of knowledge in all fields becomes obsolete every 12 months.

The irresponsible behavior of workers and management ingrained in the fabric of work in many lands, the callousness of professionals, the debasement of morals by the worship of riches, the corruption in politics and world trade all must be converted to finding a way of securing for everyone a more abundant life which does not simply consist of taking away from someone else.

Preoccupation only with self fulfillment becomes depressing, and produces the feeling that life is meaningless, so that there must be something beyond self — something which transcends individual concerns, a responsibility to our fellow man and society, from the belief that each man does have a role in shaping his destiny. The year ending brings a realization that the unexamined life is not worth living, so the beginning of a new year can provide a milepost for re-evaluation of one's past as a guide to the future, the only distinctions to be recognized are those of the soul of strong principle, of incorruptible integrity, of usefulness, of cultivated intellect, and of fidelity in seeking the truth.

Dreams, hopes, aims and purposes mark time until started marching, and finding one's self can not be accomplished so much by searching for something as rather by doing something, for it is one's daily actions that shape the inner personality. So the new year must be entered with an open-mindedness, a willingness to listen as well as to speak, a personal patience, the humility to admit mistakes and an awareness that while one's days are limited, and procrastination is a thief of time, we can make the most of every single minute.

As a member of the human race, each of us must recognize that regardless of color, class or creed, the individual's destiny is everyone's destiny and that only as we learn to live together will we move forward. History recites through the ages that though held back by tyrants, ignorance, fear, economic disaster and war, great men ultimately break the shackles and march toward a greater destiny.

From the lowest depths there is a path to the loftiest heights — the tendency to persevere, to persist in spite of hindrances, discouragements and impossibilities — it is this in all things that distinguishes the strong soul from the weak.

So in the coming year, we must use our knowledge for the good of humanity against the destructive forces of the world and the ruthless intent of man. It is a year to rededicate one's life to those things which endure.

C.M.C.

The Washington Establishment

Edward Pedrero Jr., M.D.

Abstract: The Congress of the United States is the linchpin of the Washington Establishment, a self-perpetuating coterie motivated primarily by the desire for reelection. This essay analyzes decentralization of this group's power and the bureaucratic system with its legislative and judicial functions. It suggests means by which physicians may help achieve changes in the Congress.

The American bureaucratic system of government has been described as a complex political reality. It would be better to focus upon simple, objective explanations of political reactions and events rather than seize upon imaginative, fictitious analyses and give conspiratorial explanations for bureaucratic deeds. Contrary to popular belief the bureaucrats are not the chief creators of laxity, poor management, improper actions, and wasteful, imprudent expenditures.

Something meriting the name, "Washington Establishment," exists, a hydra with each head only marginally concerned with the other's existence. The Establishment is not a malevolent or centrally directed conspiracy against people. It is the Congress, the linchpin, composed of career politicians.

Since World War II nearly 90% of congressional incumbents have sought reelection in any given election and approximately 90% have been successful. Voluntary retirement rates jumped in the early 1970s under the stimulus of significant improvement in pensions and the unpleasantries of holding office during the Watergate period. Yet, despite the infusion of fresh blood, there are indications that the new congressmen intend to match the length of the careers they replaced.

The first priority of individuals in the legislative body is continued tenure. They are engaged in a mix of three other kinds of activities: lawmaking, pork barreling (bringing home the bacon to their districts), and casework (constituents' appeals for myriad favors and services). Their convenient whipping boy is the bureaucracy which also serves as a lightening rod for organized medicine's frustrations. As long as the bureaucracy accommodates the congressmen, they will oblige with larger budgets and grants of authority.

Congressmen not only react to big government, they help make it bigger. More bureaucrats are promulgating more regulations and dispensing more money. Fewer congressmen are suffering electoral defeat. In general, the long-term welfare of the United States is merely an incidental by-product of the Washington Establishment.

Increased Staff

The nonelected congressional staff increased from 2,344 persons in 1960 to 5,109 in 1974, according to Charles B. Brownson's analysis of Annual Congressional Staff Directories, and the number of congressmen listing multiple district offices rose from 4% to 47%.

In 1977 a representative could have as many as 18 staff members requiring a payroll of more than $225,000. A senator received between $400,000 and $800,000 annually for a personal staff, plus an extra $100,000 for three staff members to aid with committee work. Ironically congressional action to augment these numbers is almost universally encouraged and applauded. The reason appears to be a naive assumption about the purposes of the staff.

Decentralization

Attempting to decentralize its power, the Congress passed the Legislative Reorganization Act in 1946. Since then the number of subcommittees have increased tremendously, weakening the seniority system and producing a surfeit of chiefs and a shortage of Indians. Decentralization created subgovernments which enabled individual congressmen to control policy decisions and influence elements of the bureaucracy. It provided a power base for senators to advertise presidential hopes, congressmen to advertise senatorial hopes and/or everyone to advertise reelection hopes.

In 1977 on an average one of every two Democrats in the House served as chairman of a subcommittee while every Senate Democrat chaired an average of two subcommittees. The most powerful committee chairman often is unable to get the legislation he wants out of his own subcommittees.

Fragmentation and stalemate often damage the ability to reach a consensus. Eleven subcommittees from six standing House committees can legitimately claim responsibility for a portion of the energy-environment policy decision. Compound the accountability by adding subcommittees in the Senate and the result is inconsistency of action.

Subcommittees interacting with various administrative units conduct much of the detailed business of government. Only the highly visible and politically sensitive issues are likely to receive attention from full committees and department level agencies.

Appropriations

The Congress has augmented legislative control over the executive department and trimmed the power of the President by enacting detailed statutes authorizing activities and regulating procedures and work methods. The statutes also remove bureaus to some extent from responsibility to department heads.

Appropriation Committees of the House and Senate and numerous subcommittees exert continuous and detailed control through the budget. The Congress is empowered to change budget proposals, a basic feature of government structure and an ideal method in the separation of powers but it has a defect. The President has no item-veto power.

The Congress may add sections or riders to the proposed budget which deal with other aspects of policy or to administration. Almost every President has objected to these riders as an attempt to evade the constitutional system of checks and balances. Debates have been going on since President Franklin D. Roosevelt first proposed reform. (Many states have delegated item-veto power in budgetary measures to their governors.)

Fifteen or more appropriation bills are passed at different times while revenue legislation is considered by other committees. Expenditures are authorized by various committees of both Houses and as a result Congress never considers the entire budget, including revenues, at one time.

Regulatory Commissions

In statutes creating the Interstate Commerce Commission (ICC) and more recently the Federal Communication Commission, the Congress specified that their activities should be conducted in "a just and reasonable manner" and in the "public interest." In the first decade of the 20th century, however, the ICC was strengthened by a number of acts to provide it with independent legislative and judicial power. Starting in the second decade of the 20th century regulatory commissions analogous to the ICC were established to control and promote various industries. In virtually every case this was the result of political pressure for some form of national control arising directly from economic problems associated with the industry concerned.

Bureaucracy

Federal administrators are deeply involved in politics in efforts to retain, solidify and expand their power within other branches of government and over the general public. They attempt to maintain a balance of political support over opposition. One important determinant of presidential control over any particular agency is the extent of that agency's contract with and support from private interest groups.

Bureaucratic Legislative Functions

In 1803 the U.S. Supreme Court's review in Marbury vs Madison firmly established that while Congress has primary responsibility for legislation, both the President and the Supreme Court have a measure of control in the law-making process.

The vague phraseology of statutes creating administrative agencies permits wide latitude in establishing regulations that are legislative in effect. The burden of reconciling conflicts is upon the bureaucracy rather than the Congress. Usually the courts are reluctant to interfere in what is considered the "policy-making" area of administrative decision-making.

The legislative function is also exercised through direct involvement in initiating and drafting laws. Many bills passed by Congress emanate directly from the administrative branch. Congressmen wishing to gain support often turn to the particular agency or agencies that will have jurisdiction over implementing the legislative proposal.

Direct administrative participation in the congressional process and willingness of Congress to delegate substantial power to administrative agencies result in the firm and significant position of bureaucracy in the legislative process.

Bureaucratic Judicial Functions

Generally, the judicial function of a regulatory agency pertains to disposition of a specific case on the basis of general rules. Judicial power is exercised on congressional grant of authority. Examples are the Federal Trade Commission, National Labor Relations Board and others usually classified as "independent regulatory commissions." It was the Federal Trade Commission which ruled that lawyers may advertise their professional services. The administrative agencies are unable in their regulations to be precise enough to prevent delegation of significant discretion to adjudication.

There is no constitutional objection to legislative power residing outside Congress, nor to judicial functions being employed by extrajudicial departments.

Administrative agencies are permitted to perform all the functions of government. The courts have seen no objection to the combination of legislative, judicial and executive power.

The staff-agency type of bureaucracy arose in response to the need to provide adequate facilities and to coordinate operations in the sprawling maze of agencies.

Conclusion

Decentralization of congressional power has been pushed so far as to become economically wasteful, humanely stultifying and ineffectual. It has created numerous subgovernments which enable individual congressmen to control policy decisions and influence elements of bureaucracy. The diminution of seniority has elevated the authority of the individual and profoundly altered the legislative process.

The anti-Washington rhetoric advocates less government, less spending, less federal manpower and less regulation. But we must not forget that less government means reduced protection for people without resources, less spending means fewer needed social programs and stark hunger for those in poverty, less government employees could mean fewer public services and less regulation could mean an end to civil rights enforcement. What is needed is better, more efficient, flexible and creative government.

Many congressmen and bureaucrats appear to be satisfying the consensus of the people when in reality public policy is hostage to the personal goals of the Washington Establishment. Congressional investigations of maladministration, mismanagement and corruption often are whitewashed or stonewalled as politics.

Physicians must help convince congressmen of the substance and not the emotion of medical issues. One of the most reliable ways to achieve change is to change congressmen. Physicians should examine possible alterations in the socioeconomic homogeneity of their local congressional district and the effectiveness of the congressional incumbent.

American Medical News reports that the American Political Action Committee does not keep an index on how the candidates it supports vote. AMPAC should stipulate and articulate political criteria for candidate support in the Congress.

A joint legislative-executive commission of outstanding citizens including physicians is needed to conduct an inquiry into the federal budgetary system. Granting the President item-veto in appropriation bills would be a checks and balances measure for the numerous uncoordinated decisions motivated primarily by congressional desire for reelection and added to appropriate bills as riders. The item-veto could be conferred by Congress by writing pertinent language in each appropriation bill but this appears unlikely. The valid way to handle the problem may be a constitutional amendment.

The Washington Establishment is allowed by special acts of grace to accommodate its reasoning to the answer it needs. Logic is required to differentiate between the frivolous and extravagant and the basic and essential. It is time to end uncorrected obsolescences and economic shortcomings. Each physician should be appraiser of the neglected opportunities of his respective representative and senator.

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While we're growing up, a lot of us spend a great deal of time worrying about what the world thinks of us. By the time we reach midlife, we realize the world wasn't paying that much attention.

SPECIAL ARTICLE

Proposed 1979 Florida State Health Plan

Statement of Paul J. Popovich, M.D.

My name is Paul J. Popovich, M.D. I am a practicing physician in Brevard County, Chairman of the Florida Medical Association Committee on Health Systems Agency, and a member of the Local Council for the Health Systems Agency of East Central Florida, Inc.

I appreciate this opportunity to express my views regarding the Proposed 1979 Florida State Health Plan.

Mr. Chairman, there are many positive ideas expressed in the Proposed 1979 Florida State Health Plan which I am pleased to support and endorse. The references to the American lifestyle and how smoking, excessive alcohol consumption, stress, and lack of exercise are leading to cardiovascular disease, accidents, suicides, pulmonary disease, and many other killers, are of primary importance. The American lifestyle is a basic reason why we are spending so much in this country for medical and health care.

I am pleased that the Proposed 1979 Florida State Health Plan reflects the need for policymakers and Floridians to concentrate on programs of prevention and health education especially as these programs relate to our children and youth. We must switch our attention to prevention and health education so that our children will understand the importance of maintaining and being responsible for their own personal health. In order to accomplish this, I hope that the Statewide Health Coordinating Council (SHCC), in developing future State Health Plans, will look even more to existing public and private agencies and organizations for input and expertise. The Florida Medical Association, for example, received no request to develop specialty panels to work with the SHCC in refining and strengthening the Proposed 1979 Florida State Health Plan nor did any of Florida's 38 recognized medical specialty groups receive such a request.

The Proposed 1979 Florida State Health Plan, if it is ever going to be effectively utilized as a basic planning document, must be refined to reflect accurate, up-to-date, and supportive information and statistics. It is imperative that unsupported conclusions, narratives and statistical information be eliminated from the text. The chief criticisms I have received from physicians who have reviewed the Proposed Plan are:

1. There are many inconsistencies in statements and conclusions.

2. The statistical information and data used in several of the fascicles are outdated or not derived by the use of proven statistical methods.

3. There is a general lack of professional input and reference in several of the summary analyses.

Based on a review by representatives of medical specialty groups and members of the Florida Medical Association Committee on Health Systems Agency, there are particular concerns of the following fascicles of the Proposed 1979 Florida State Health Plan: Cardiovascular Disease; Cancer; Mental Health; Obstetric Services; Acute Care Beds, and Computerized Tomography Scanners. Time is too short for me to provide you with a detailed commentary on each subject, but for the sake of emphasizing my concern, I would like to give you a few examples.

This statement was presented before the Statewide Health Coordinating Council Public Hearing on September 19, 1979.

Dr. Popovich is Chairman of the Committee on Health Systems Agency of the Florida Medical Association and a member of the local council for the Health Systems Agency of East Central Florida, Inc.

Cardiovascular Disease

Two of the major programs, according to our reviewers, that should have priority in terms of implementation even before cardiopulmonary resuscitation are the establishment of a 911 emergency services system throughout the state and improvement in the quality of emergency medical services to assure that life can be sustained from the site of trauma to the point of treatment. These two high priority items are shown on page 177 of the Proposed Plan as actions considered but not selected.

Cancer

This fascicle was reviewed by the American Cancer Society, Florida Division, as well as by representatives of various specialties and members of our Health Systems Agency Committee. Based on the reply of the Cancer Society, it is apparent that their input was not solicited in the development of this section of the Proposed Plan. The entire fascicle needs to be updated, reworked, edited and presented in a more logical and realistic approach to the problem of cancer. Two factors that hold great potential for decreasing mortality rates in cancer, hemoccult examination and antismoking education, are not even addressed in the Proposed 1979 Florida State Health Plan.

Mental Health

I find it difficult to understand the apparent conclusion in this fascicle which minimizes biological, biochemical and nonsociological factors in the etiology and treatment of psychiatric disorders. Also, I am concerned with the lack of reference to psychiatrists and psychiatric care. This fascicle needs input from medical professionals so as to balance the apparent sociological leaning of the author.

Obstetric Services

In general, this fascicle is wordy, riddled with jargon and includes much information based on the existing maternal and infant care (MIC) and Women, Infants and Children (WIC) programs. In conclusion, it is stated that the MIC Program is unable to present evidence that its efforts improve pregnancy outcomes; yet earlier in the document on page 268 it is stated that substantial improvement in pregnancy outcomes measured in terms of total perinatal and total neonatal death rates have been realized. This is an inconsistency.

Also, taking a hard line on the volume of 1,500 deliveries is extremely unrealistic and not appropriate for most hospitals; in fact, a recent article from the *Journal of Obstetrics and Gynecology* points out that only two states have succeeded in regionalizing obstetric services along federal guidelines.

Acute Care Beds

This fascicle appears to disregard some of the recommendations of the Statewide Health Coordinating Council's own Bed Need Task Force. Consideration for out-of-state and out-of-country patients is not presented. The 3.5 beds per 1,000 is not realistic for most areas of the state when you take into account the influx of tourists during the winter, the large number of elderly, and the ever-increasing trend of people from out-of-state such as in Escambia County and Dade County to use Florida hospitals. The statement that an empty hospital bed is roughly one half to three quarters the cost of a full hospital bed is not supported by documented facts but rather is an opinion. The data, information, and methodology used to develop this fascicle are not refined to a point of providing reliable information to support many of the conclusions expressed by the author. The problem with using figures that are not supportive is the tendency for planners to lock in on them regardless of the consequences and to provide the figures to policymakers as facts.

Computerized Tomography Scanners

The thrust of this fascicle is to project the CT Scanner as a costly piece of technical equipment that is used as a prime revenue generator. In addition, the Proposed Plan states on page 303: "The relatively low financial risk, given initial charges on rates per procedure and the growing number of referrals, gives hospitals and physicians a strong incentive to purchase the equipment."

These are totally unsupported conclusions, demonstrate inadequate review, and reflects little understanding of the utilization of scanners. As a radiologist, I resent the implication that I want a certain piece of equipment because it is a "prime revenue generator." The current use and potential use of scanners is without a question one of the greatest steps forward in medicine. The elimination of pain and suffering for patients who would otherwise have to face a wide variety of painful diagnostic tests is of prime importance. I suggest that recent studies conducted by EMI Corporation regarding patient cost savings as a result of scanning be carefully reviewed.

It is also contradictory to state as fact that scanners are not being operated cost effectively and in the same fascicle have as an objective 12.D.1, i.e.: "to determine the true cost effectiveness of CT Scanners in diagnostic radiology by 1980."

General Use of Data and Cost Projections

Once again, as with the 1978 Florida State Health Plan, the current Proposed Plan inconsistently applies population statistics. When it is convenient, population figures reflecting the elderly and tourists are used and when it is not convenient to support a point they are conveniently factored out. This abuse of statistics and data has no place in a document of this nature.

Future plans developed by the Statewide Health Coordinating Council must begin to project costs and potential savings. Planning as idealistic as the Proposed 1979 Florida State Health Plan will never be realistic until it is shown what the total implementation price tag will be. If you totaled the cost to implement your current plan, you might find it would significantly increase the cost of health care in Florida.

The Proposed 1979 Florida State Health Plan is replete with statements which may appear to be factual but are not supported by narrative, tables or charts. A plan of this nature should be based on facts which are supported. For example, on page 90, paragraph 3, the Proposed Plan states: "However, it appears from recent experience that there is a tendency toward the acquisition of new medical technology even in the absence of demonstrated benefits."

This is a conclusion reached by the author with not one fact to support the statement nor consideration given to the countless hours and money provided by the manufacturer to engineer, test and refine equipment.

Conclusion

The greatest emphasis of the Proposed 1979 Florida State Health Plan is not planning. It is instead a document heavily slanted towards recommending legislation to regulate cost. Cost is important and needs to be addressed but so do the needs and expectations of Floridians. Both factors must be kept in mind during the planning process or Florida may be faced with a situation where preoccupation with cost will result in rationing of health and medical care. If rationing of care is what the Statewide Health Coordinating Council feels should be done, I recommend that next year's plan include a fascicle entitled "Rationing of Health and Medical Care" so that all Floridians can have an opportunity to express their desires as to what will and will not be available or readily accessible to them. In the not too distant future, the Congress, State Legislature, and the SHCC will find that we have all been maneuvered by social health planners into a position of determining who will and who will not recieve care. With this tremendous responsibility soon to be placed on your shoulders, I strongly urge that the SHCC take the time to see that the basic planning document is sound, factual and truly meets the needs of the people because your loved ones and mine deserve such consideration.

You will be receiving in the near future a more detailed explanation and recommendations for the redrafting of the problem fascicles.

● Dr. Popovich, Brevard Hospital, Melbourne 32901.

You are as young as your faith, as old as your doubt; as young as your confidence, as old as your fear; as young as your hope, as old as your despair. In the central place of every heart there is a recording chamber; so long as it receives messages of beauty, hope, cheer and courage, so long are we young. When the wires are all down and your heart is covered with the snows of pessimism and the ice of cynicism, then and then only are you grown old.

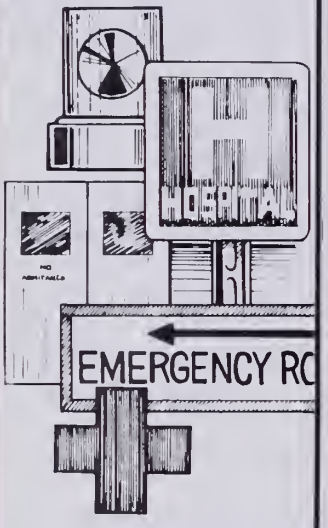
Douglas MacArthur

MEDICAL MESSAGE
from the Florida Doctors

EMERGENCY MEDICINE

Editors Note: The following is a true story. It could have resulted in a bad ending. Don't let it happen to you.

Recently a family — husband, wife and young child — moved to one of Florida's large metropolitan areas. All were in good health, having seen their physicians on a regular basis in their former hometown. No efforts were made to find new doctors or locate emergency medical facilities.



The furniture was arranged, the boxes unpacked, and the little girl enrolled in school. The husband found the best route to and from his office while the wife located a dry cleaner, the grocery store and a beauty shop. The family took walks on a nearby beach and all was well.

One afternoon the little girl staggered in the house crying for her mother. Blood was spattered over her clothes and dripping rapidly from her chin. Only minutes earlier the mother had observed her and a friend riding bicycles in and off the street area in front of the home. After the mother went inside, the little girl rode from behind a screen of shrubbery into the side of a neighbor's car as it turned into the driveway. Neither saw the other until it happened.

The mother immediately wrapped the little girl in a blanket, placed her in the car and started driving to an area where she recalled seeing a directional sign for a hospital. She wasn't even sure if the hospital operated an emergency room. It did.

Seven stitches closed the gash and a number of x-rays showed there were no broken bones. There was no permanent damage to the child.

The doctors of Florida urge you, when moving to a new area, immediately find:

The location of emergency medical facilities; the telephone number of the local fire department and if it operates emergency medical vehicles; a telephone number for the local police department; local doctor(s) for the family.

Don't suddenly be faced with the screams of an injured child without knowing where to turn. Precious life-saving minutes could be wasted in trying to find a source of emergency treatment. It could be the most important preventive medicine you ever practiced.

This is a medical message from the Florida Medical Association in behalf of the doctors of Florida.

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ORGANIZATION

Dr. Robert B. Katims of Miami Heads Medical Examiners

Robert B. Katims, M.D., former President of the Dade County Medical Association, has been elected Chairman of the new Florida State Board of Medical Examiners.

He was one of 11 Floridians appointed to the Board on October 18 by Gov. Bob Graham. The Miami endocrinologist was chosen to lead the new Board at its organizational meeting in Tallahassee in November.

Robert Webster, M.D., of Tallahassee, one of only two members of the old BME to be reappointed, was elected Vice Chairman of the Board. Dr. Webster is a member of the Board of Governors of the Capital Medical Society and has been a member of the FMA House of Delegates for 20 years.

Dr. Katims was appointed for a four-year term on the Board of Medical Examiners as were John N. Sims, M.D., of Fort Pierce; and Raul J. Valdes-Fauli of Coral Gables, a Cuban-born attorney and one of the BME's two lay members.

Graham appointed Richard Conard, M.D., of Bradenton; Richard Feinstein, M.D., of Miami; Alberto M. Hernandez, M.D., of Miami, and Carver Boyd, M.D., of Pensacola, to three-year terms.

Named to two-year terms were: Jeraldine Smith of Tallahassee, a law student at Florida State University; and Dana Wallace, M.D., of Hollywood.

Dr. Webster, and Benjamin Cole, M.D., of Orlando, the only members of the old Board of Medical Examiners, were given two-year terms.

The old Medical Practice Act was "sunset" last year, and the 1979 Legislature enacted a new one. The terms of all BME members therefore expired, and Gov. Graham had the opportunity to appoint an all-new Board.

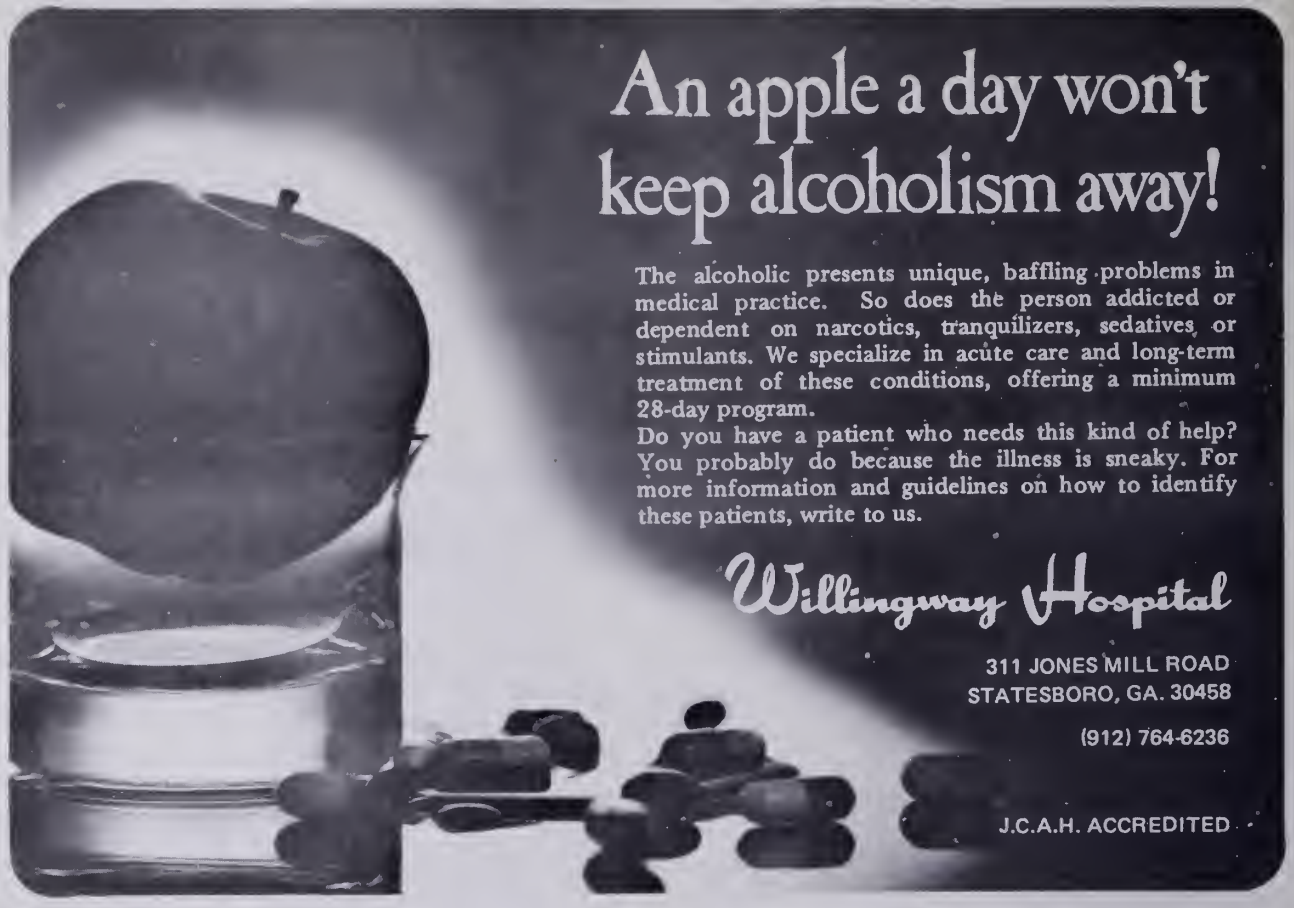
The Board consists of nine physicians who have actively practiced medicine for the past four years but who are not affiliated with a medical college; and two lay members. The appointments are subject to Senate confirmation.

Joint FMA-Florida Bar Committee Is Established

Jere W. Annis, M.D., of Lakeland, has been named Chairman of a new Joint FMA-Florida Bar Liaison Committee.

The Committee was appointed by FMA President Richard S. Hodes, M.D., in consultation with Mr. David Shear, President of the Florida Bar. Purpose of the Committee is to explore areas of mutual concern and to attempt to arrive at solutions to problems.

The Committee will consider a proposed Medico-Legal Code.



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Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

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Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

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Drug interactions. *Aspirin:* used concomitantly may decrease Motrin blood levels. *Coumarin:* Bleeding has been reported in patients taking Motrin and coumarin.

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Incidence greater than 1%

Gastrointestinal: The most frequent type of adverse reaction occurring with Motrin is gastrointestinal (4% to 16%). This includes nausea,* epigastric pain,* heartburn,* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness,* headache, nervousness. **Dermatologic:** Rash* (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

*Incidence 3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

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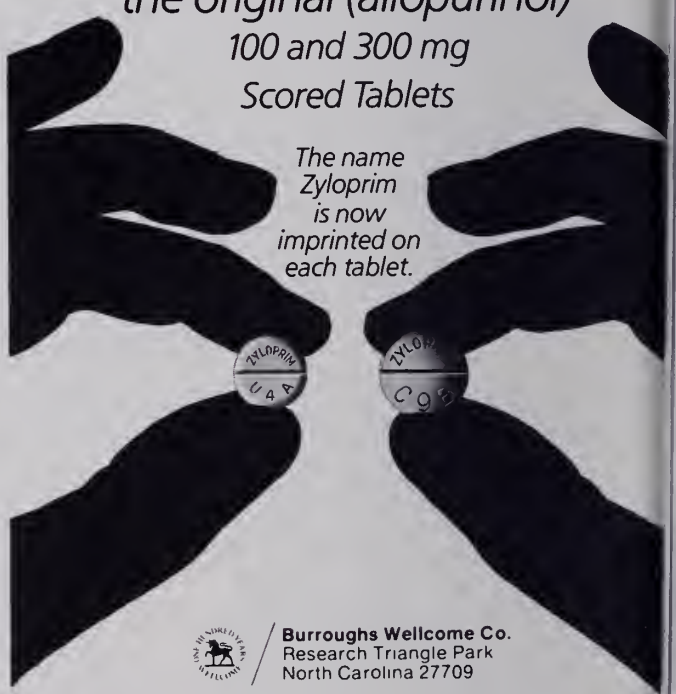
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Book Reviews

Book Review Editor

F. Norman Vickers, M.D.

Clear Skin — A Step-By-Step Program to Stop Pimples, Blackheads, Acne by Kenneth L. Flandermeyer, M.D. 205 Pages. Price $8.95. Little, Brown and Company, Boston, 1979.

Clear Skin is a book for patients with acne who wish to treat themselves. The physiology and pathology of acne are described in lay terms along with medications aimed at the peeling or desquamating method of treatment. Myths and wive's tales are enumerated and disposed of in order. The basic concept of avoiding oily substances, including most cosmetics, on the skin, a regimen of twice or more times a day washing and applying a desquamating agent is elaborated in detail. Like TBC, the disease can be arrested, but constant maintenance is required subsequently. The adjunctive use of antibiotics and surgical procedures such as dermabrasion, chemical peeling and cryotherapy are explained on a patient level.

Again— a manual for patients with acne.

Hoyt C. Taylor, M.D.
Port St. Lucie

Dr. Taylor is in the practice of Emergency Medicine and Obstetrics in Port St. Lucie, Florida.

How To Prevent Home Accidents and Handle Emergencies Effectively by Boyce N. Berkel, M.D. 131 Pages. Price $7.50 plus 45 cents postage and handling (Paperback). Privately printed by Dr. Berkel, 2245 McMullen Booth Road, Clearwater, FL 33519, 1979.

Dr. Berkel draws on his experience in the emergency departments and has developed a small book which, if advice is followed, will help in the prevention and emergency treatment of accidents. As expected, there are comments on falls, burns, poisonings and animal bites. The essentials of cardiopulmonary resuscitation are presented. Color photographs of poisonous snakes by Dr. L.H.S. Van Mierop are excellent. Van Mierop's "Poisonous Snakebite Review" in JFMA 1976 is referenced. A questions and answer section answers diverse questions such as hot or cold compresses for a sprain, treatment of nosebleed and swimmers ear. This book, though brief, covers the essentials of advice and treatment for most emergency situations.

F.N.V.

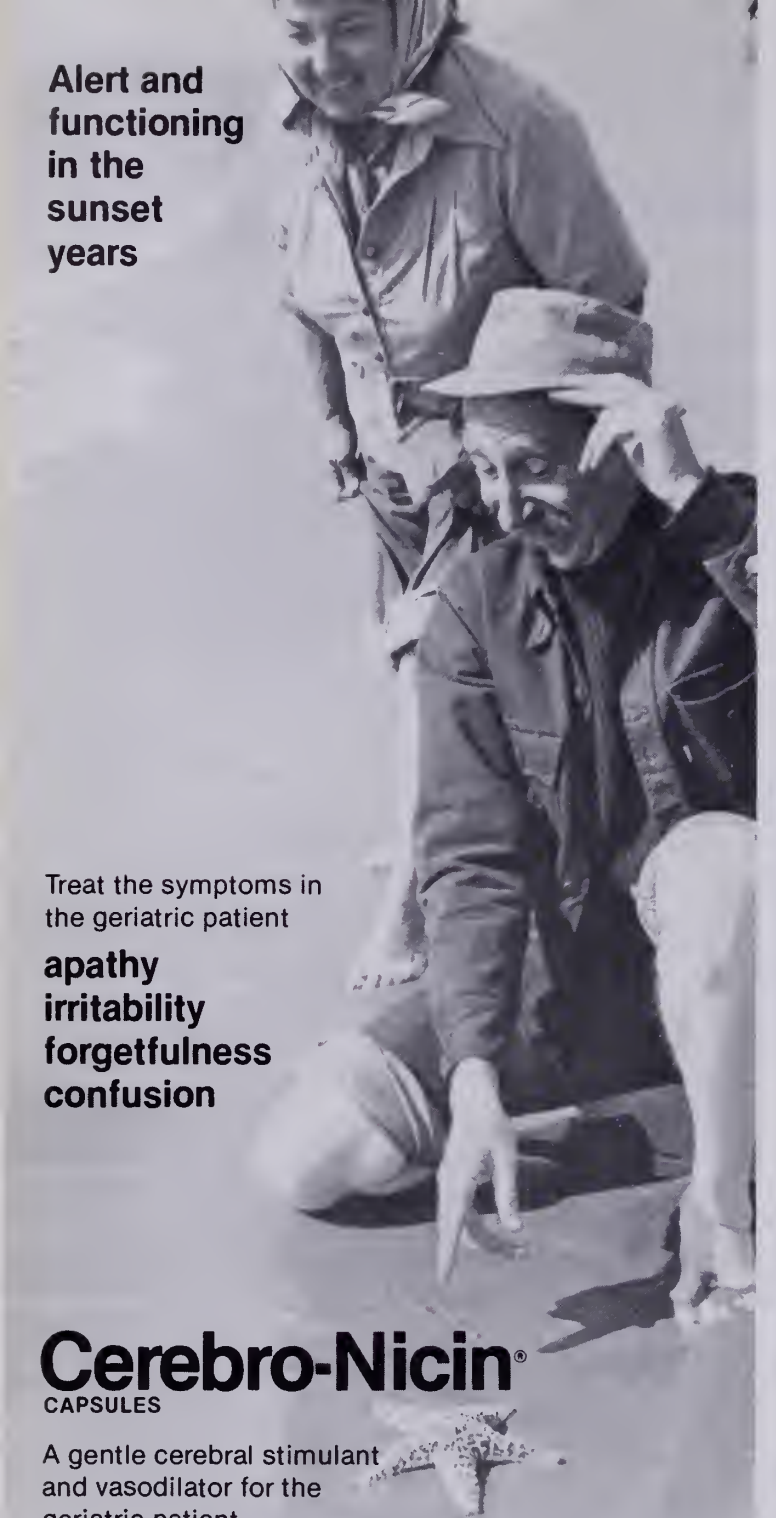
The Living End by Stanley Elkin. 148 Pages. Price $7.95. E.P. Dutton, New York, 1979.

If you liked Mark Twain's *Letter From The Earth*, you will probably like Stanley Elkin's *The Living End*. It has also been described as a contemporary version of Dante's *Divine Comedy*, set in Heaven, Hell and Minneapolis — St. Paul.

His description of Hell is, "Because it was the fate of the damned to run of course, not jog, run, their (urine) on fire and their (feces) molten, boiling sperm and their ovaries frying; what they were permitted of body sprinting at full throttle, wounded gallop, burning not fat — fat sizzled off in the first seconds, bubbled like bacon and disappeared, evaporate as steam, though the weight was still there, still with you, its frictive drag subversive as a tear in a kite — and not even muscle, which blazed like wick, but the organs themselves, the liver scorching and the heart and brains at flash point, combusting the chemistries, the irons and phosphates, the atoms and elements, conflagrating vitamin, essence, soul, yet somehow everything still within the limits if not of endurance then of existence. Damnation strictly physical, nothing personal, Hell's lawless marathon removed from character."

One of the main characters, God the Father, explains, if not justifies his ways. In all, a humorous version. As I said, if you didn't like *Letter From The Earth*, by Mark Twain then don't bother with this one.

F.N.V.



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The Chemistry of Human Behavior by Herbert L. Meltzer, Ph.D. 261 Pages. Illustrated. Price $17.95 (cloth). Nelson-Hall Publishers, Chicago, 1979.

Cry Babel, The Nightmare of Aphasia and a Courageous Woman's Struggle to Rebuild Her Life by April O. Armstrong. 252 Pages. Price $8.95. Doubleday & Company, New York, 1979.

Annual Review of Neuroscience with 31 contributing authors. 555 Pages. Annual Reviews, Inc., Palo Alto, California, 1979.

Norethindrone, The First Three Decades edited by Mary Jean Pramik. 100 Pages. Syntex Laboratories, Palo Alto, California, 1978.

Family Health in an Era of Stress conducted by Yankelovich, Skelly and White, Inc. 192 Pages (plus packet). General Mills, Inc., Minneapolis, Minnesota, 1979.

Correlative Neuroanatomy & Functional Neurology, 17th Edition, by Joseph G. Chusid, M.D. 464 Pages. Illustrated. Price $12.00. Lange Medical Publications, Los Altos, California, 1979.

Review of Allied Health Education: 3, Joseph Hamburg, General Editor. 161 Pages. Price $7.50. The University Press of Kentucky, Lexington, Ky., 1979.

Family Health and Home Nursing, American National Red Cross. 626 Pages. Illustrated. Price $3.95. Doubleday & Company, Inc., New York, 1979.

Review of Medical Physiology, 9th Edition, by William F. Ganong, M.D. 618 Pages. Illustrated. $14.00. Lange Medical Publications, Los Altos, California, 1979.

Stop Forgetting by Dr. Bruno Furst. 340 Pages. Price $5.95. Doubleday & Company, Inc., New York, 1979.

How To Improve Your Child's Behavior Through Diet by Laura J. Stevens and Rosemary B. Stoner. 346 Pages. Price $9.95. Doubleday & Company, Inc., New York, 1979.

Helping Hospital Trustees Understand Physicians by Richard E. Thompson, M.D. 82 Pages. Price $9.00. American Hospital Association, Chicago.

Child Guidance by Samuel Kahn, M.D., Ph.D., F.R.S.H. 134 Pages. Price $10.00. Philosophical Library, Inc., New York, 1979.

Current Surgical Diagnosis and Treatment, Fourth Edition by J. Englebert Dunphy, M.D., and Lawrence W. Way, M.D. 1162 Pages. Price $19.00. Lange Medical Publications, Los Altos, California, 1979.

The Vitamin Book by Rich Wentzler. 224 Pages. Price $4.95. Doubleday & Company, Inc., New York, 1979.

The Truth About Senility — And How To Avoid It by Lawrence Galton. 244 Pages. Price $9.95. Thomas Y. Crowell Company, New York, 1979.

Drug Induced Nutritional Deficiencies by Daphne A. Roe, M.D. 272 Pages. The Avi Publishing Company, Inc., Westport, Connecticut, 1978.

Alcohol and the Diet by Daphne A. Roe, M.D. 229 Pages. The Avi Publishing Company, Inc., Westport, Connecticut, 1979.

Cooking Creatively for Your Diabetic Child by Caroline Hastings Babington. 224 Pages. Price $8.95. Doubleday & Company, Inc., New York, 1979.

Vitamin C Against Cancer by H. L. Newbold, M.D. 363 Pages. Price $10.95. Stein and Day, New York, 1979.

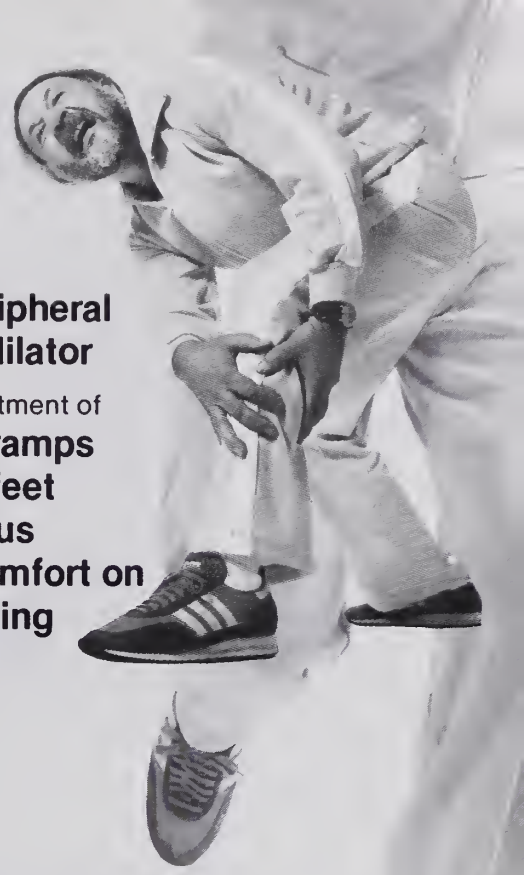
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Review of Physiological Chemistry by Harold A. Harper, Ph.D., Victor W. Rodwell, Ph.D., and Peter A. Mayes, Ph.D., D. Sc. 702 Pages. Price $14.50. Lange Medical Publications, Los Altos, California, 1977.

The Heritage of Aviation Medicine, An Annotated Directory of Early Artifacts, by Robert J. Benford, M.D. 122 Pages. Illustrated. Price $4.50. Aerospace Medical Association, Washington, D.C., 1979.

What You Should Know About Medical Lab Tests by Bernard Kliman, M.D. and Raymond Vermette, M.S., with Ernest Kolowrat. 207 Pages. Price $9.95. Thomas Y. Crowell Company, New York, N.Y., 1979.

A little kindness from person to person is better than a vast love for all mankind.



A peripheral vasodilator

for treatment of
leg cramps
cold feet
tinnitus
discomfort on standing

LIPO-NICIN®

Nicotinic Acid Therapy

For patient's
comfort/convenience
in choice of
3 strengths

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LIPO-NICIN®/300 mg.

Each time-release capsule contains:
Nicotinic Acid .....300 mg.
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Thiamine HCL (B-1) .....25 mg.
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in a special base of prolonged therapeutic effect.
DOSE: 1 to 2 tablets daily.
AVAILABLE: Bottles of 100, 500.

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LIPO-NICIN®/250 mg.

Each yellow tablet contains:
Nicotinic Acid .....250 mg.
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Ascorbic Acid .....150 mg.
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Riboflavin (B-2) .....2 mg.
Pyridoxine HCL (B-6) .....10 mg.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500.

LIPO-NICIN®/100 mg.

Each blue tablet contains:
Nicotinic Acid .....100 mg.
Niacinamide .....75 mg.
Ascorbic Acid .....150 mg.
Thiamine HCL (B-1) .....25 mg.
Riboflavin (B-2) .....2 mg.
Pyridoxine HCL (B-6) .....10 mg.
DOSE: 1 to 5 tablets daily.
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Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN® 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient.

Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur.

Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

Write for literature and samples

BROWN THE BROWN PHARMACEUTICAL CO., INC.
2500 West Sixth Street, Los Angeles, California 90057

REFER TO PDR

Florida Medical Association Auxiliary, Inc.

FOURTEENTH ANNUAL BENEFIT ART SHOW

Exhibit Rules and Regulations

Read Rules Carefully

1. All entries must be original work.
2. Pictures must be framed and wired for hanging. (Stands will be provided for sculpture, etc.)
3. Each entry must have a typed card indicating Name, Address, Medium, Dimensions and Title. Please list price if entry is for sale; otherwise, mark not for sale (NFS).
4. Only one artist's name should be listed for each registration slip.
5. A registration fee of $10 will be charged for each entry. Entry fees are tax deductible.
6. All registration slips and checks must be sent in together no later than April 23, 1980.
7. All pre-registered entries are to be delivered by hand to the Exhibit Hall at the Diplomat Hotel no later than 3:00 p.m. Wednesday, May 7. Shipped entries will be refused.
8. All entries must remain on exhibition until noon Saturday, May 10. They MUST be picked up between noon and 1:00 p.m., Saturday.
9. We will not be responsible for entries not picked up by 1:00 p.m., Saturday, May 10, 1980.
10. Doctors, their wives and children are eligible to enter. Entry fees will be donations to AMA-ERF, divided equally among Florida medical schools.

Kindly enter my registration to show in the Benefit Art Show.

Fee of $ _____ for _____ entries is enclosed. I agree to abide by the rules and regulations for exhibiting material in the show.

Name _____

Address _____

City _____ County _____

I will be showing in the following categories: Please check (X) appropriate category (categories) applying to your entry (entries).

( ) A. Painting. Include any media in color: acrylic, oil, casein, collage, watercolor, pastel, etc.

Size: _____ (H) x _____ (W) To be hung on wall.

( ) B. Graphics. Include a pen and ink, charcoal, photography, etc.

Size: _____ (H) x _____ (W)

( ) C. Crafts. Include sculpture, pottery, ceramics, mosaic, weaving, jewelry, etc.

Size: _____ (L) x _____ (D) x _____ (H)

( ) I am the son/daughter of a Florida physician. Age _____

Judges will give "Awards of Merit" and "Best in Show." An "Editor's Award," given by the Journal of the Florida Medical Association, will be used on the cover of a future issue of the FMA Journal.

A registration fee of $10 will be charged for each entry. Make checks payable to:

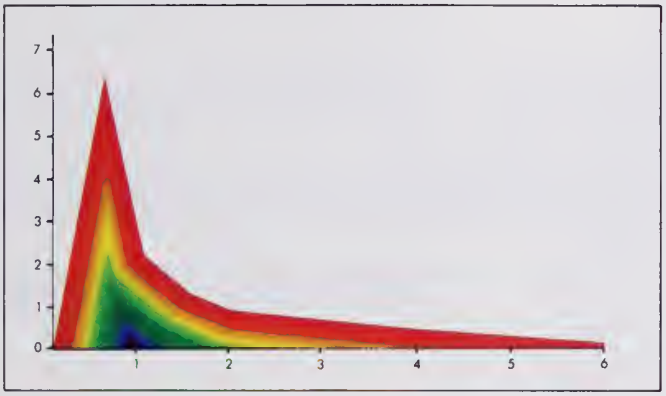
FMA-A Art Show
c/o Mrs. Carlos G. Llanes
11225 S.W. 58th Court
Miami, Florida 33156

NOTE: It is most important to know the size of your art objects, paintings, etc., to enable us to display them more professionally. We will not be responsible for damage or loss of any entry.

REGISTRATION DEADLINE APRIL 23, 1980.

Judging will take place beginning at 9:00 a.m. on Thursday, May 8, 1980.

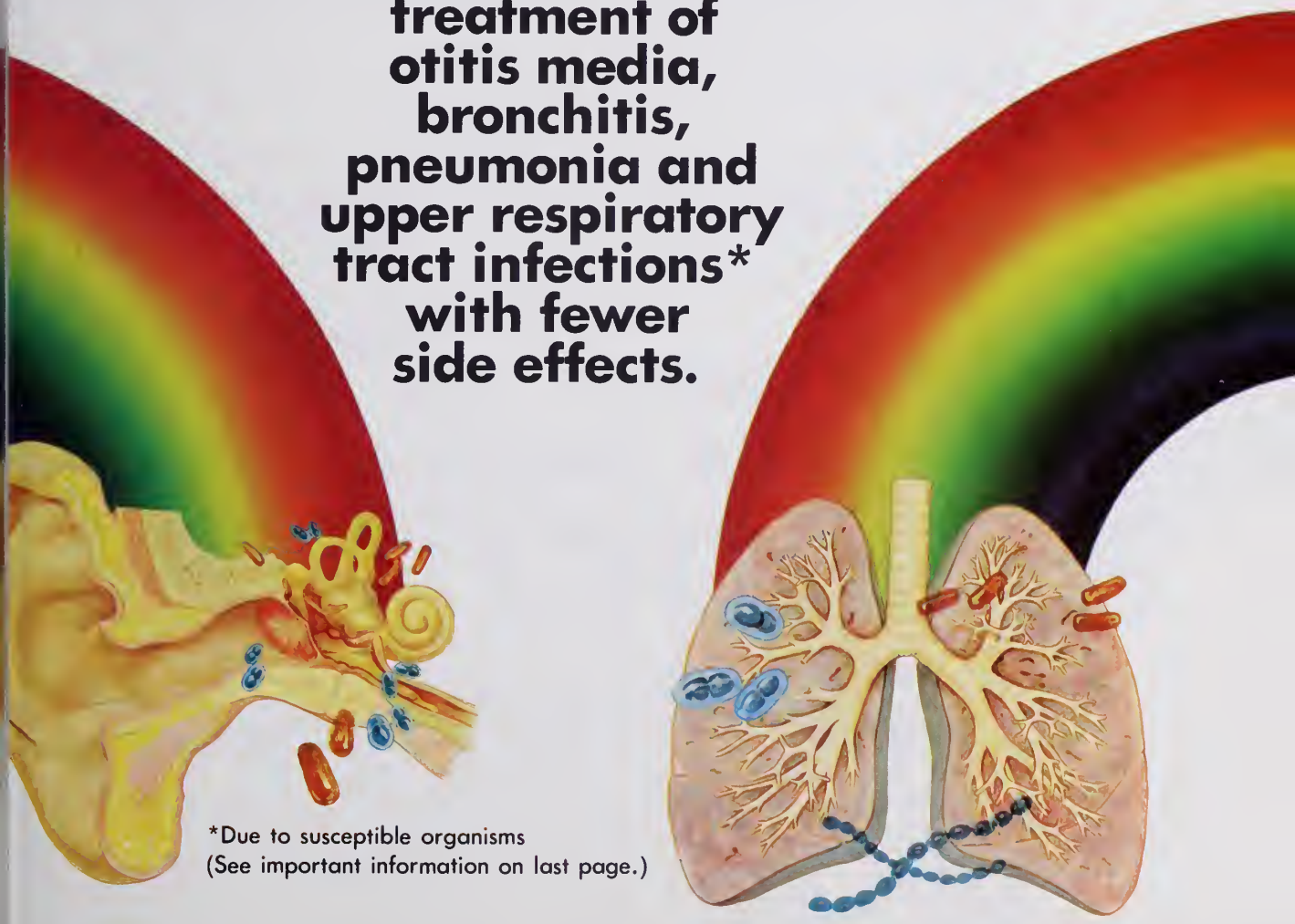
more than just spectrum



New CYCLAPEN®

(cyclacillin) Tablets/ Suspension

Efficacy proven in the treatment of otitis media, bronchitis, pneumonia and upper respiratory tract infections* with fewer side effects.



*Due to susceptible organisms
(See important information on last page.)

New CYCLAPEN®
(cyclacillin) Tablets/ Suspension

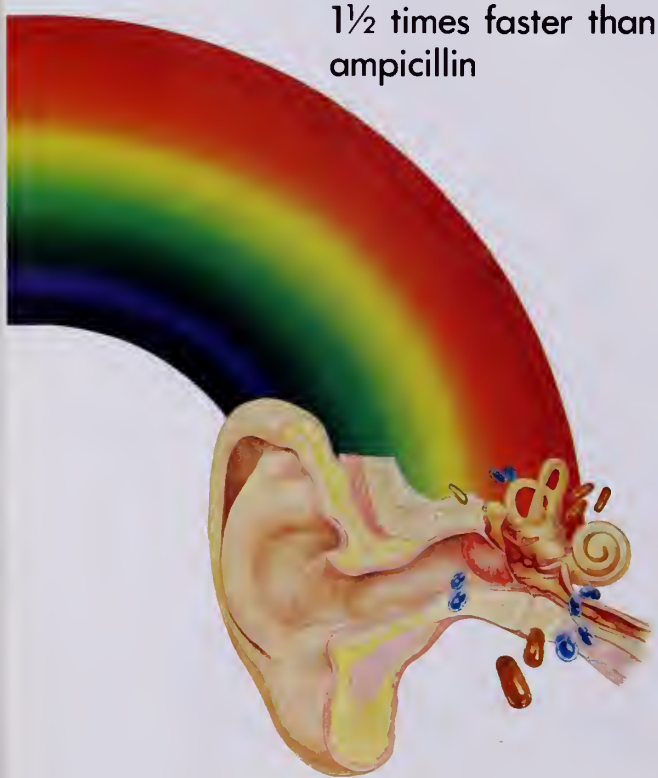
efficacy with fewer side
ampicillin confirmed in
studies of 2,58

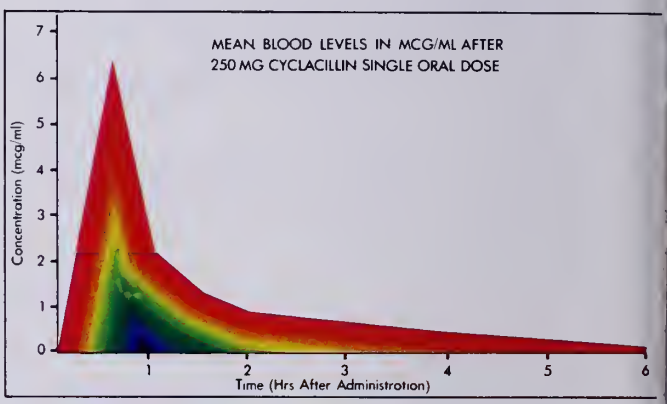
Rapid, virtually complete absorption from GI tract

Rapid onset of action—mean peak serum levels within 30 minutes

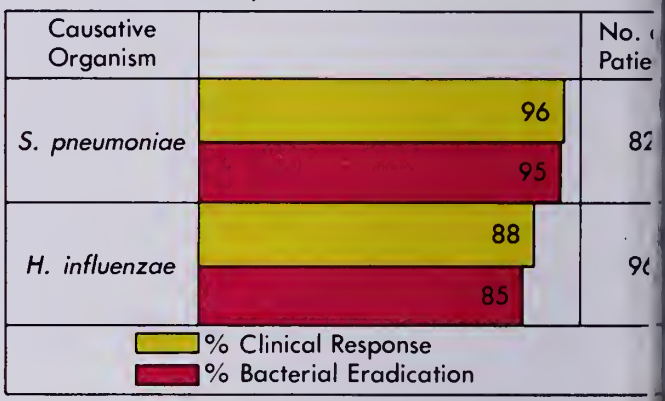
Exceptionally high peak blood levels—3 times greater than ampicillin (clinical efficacy may not always correlate with blood levels)

Rapidly excreted unchanged in the urine—1½ times faster than ampicillin





Clinical efficacy of CYCLAPEN® in otitis media†



more than just spectru
in otitis media

*Includes all patients treated. 2,415 evaluated for safety. 1,819 evaluated for efficacy.

†Due to susceptible organisms.

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ffects than
louble-blind
atients*



ver side effects with CYCLAPEN® in
uble-blind studies to date[1,2]

Total number of drug-related side effects in all patients	
YCLAPEN®	128 of 1,286 (10%) of patients
ampicillin	202 of 1,129 (18%) of patients
Difference statistically significant (P <0.001)	

CLAPEN® (cyclacillin)
fective for otitis media† in children

Excellent clinical results in eliminating the
wo most common causative organisms in
otitis media

Significantly lower incidence of diarrhea
and skin rash in children treated with
CYCLAPEN® Suspension

	diarrhea	rash
CYCLAPEN	9.1%	2.1%
ampicillin	19.2%	5.8%
	P < 0.001	P < 0.03

old JA, Hegarty CP, Deitch MW, Walker BR:
ouble-blind clinical trials of oral cyclacillin
d ampicillin, *Antimicrob Ag Chemother*
:55-58, (Jan.) 1979.

ata on file, Wyeth Loborotories.

important information on next page.)

In bronchitis, pneumonia and upper respiratory tract infections†

High cure rate with CYCLAPEN®		
Causative Orgonism	Bronchitis/Pneumonio†	No. of Potients
S. pneumoniae	100 / 95	73
Chronic Bronchitis† (ocute exacerbation)		
H. influenzae	92 — Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H influenzae*	12
Streptococcal Sore Throot†		
Group A beto-hemolytic Streptococcus	100 / 86	44
% Clinicol Response % Bocterial Erodicotion		

more than just spectrum
CYCLAPEN®
(cyclacillin) Tablets/ Suspension

Wyeth Laboratories
Philadelphia, Pa 19101

New from Wyeth Laboratories

CYCLAPEN®
(cyclacillin) Tablets/ Suspension



Usual children's dosage: 50 to 100 mg/kg/day in equally spaced doses, depending on severity.

more than just spectrum in otitis media, bronchitis, pneumonia, and upper respiratory tract infections*

- Rapid, virtually complete absorption from GI tract
- Rapid onset of action—mean peak serum levels within 30 minutes
- Exceptionally high peak blood levels—3 times greater than ampicillin (clinical efficacy may not always correlate with blood levels)
- Rapidly excreted unchanged in the urine—1½ times faster than ampicillin
- Significantly fewer episodes of diarrhea and skin rash than reported with ampicillin in studies to date
- Excellent clinical response and outstanding bacterial eradication documented in double-blind studies involving 2,581 patients
- New CYCLAPEN® Suspension—great-tasting raspberry punch flavor

*Due to susceptible organisms.

How Supplied

CYCLAPEN® (cyclacillin) tablets:
250 mg scored tablets
500 mg scored tablets

Indications

Cyclapen® (cyclacillin) has less in vitro activity than other drugs in the ampicillin class of antibiotics and its use should be confined to the indications listed below.

Cyclapen® is indicated for the treatment of the following infections:

RESPIRATORY TRACT
Tonsillitis and pharyngitis caused by Group A beta-hemolytic streptococci
Bronchitis and pneumonia caused by *S. pneumoniae* (formerly *D. pneumoniae*)
Otitis Media caused by *S. pneumoniae* (formerly *D. pneumoniae*) and *H. influenzae*
Acute exacerbation of chronic bronchitis caused by *H. influenzae**

*Though clinical improvement has been shown bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzae*.

SKIN AND SKIN STRUCTURES (integumentary) infections caused by Group A beta-hemolytic streptococci and staphylococci, non-penicillinase producers.

URINARY TRACT INFECTIONS caused by *E. coli* and *P. mirabilis*. (This drug should not be used in any infections caused by *E. coli* and *P. mirabilis* other than urinary tract infections.)

NOTE: Cultures and susceptibility tests should be performed initially and during treatment to monitor the effectiveness of therapy and the susceptibility of bacteria. Therapy may be instituted prior to the results of sensitivity testing.

Contraindications

The use of this drug is contraindicated in individuals with a history of an allergic reaction to penicillins.

Warnings

CYCLACILLIN SHOULD ONLY BE PRESCRIBED FOR THE INDICATIONS LISTED IN THIS INSERT.

CYCLACILLIN HAS LESS *IN VITRO* ACTIVITY THAN OTHER DRUGS OF THE AMPICILLIN CLASS ANTIBIOTICS. HOWEVER, CLINICAL TRIALS HAVE DEMONSTRATED THAT IT IS EFFICACIOUS FOR THE RECOMMENDED INDICATIONS.

SERIOUS AND OCCASIONAL FATAL HYPERSENSITIVITY (ANAPHYLACTOID) REACTIONS HAVE BEEN REPORTED IN PATIENTS RECEIVING PENICILLIN.

ALTHOUGH ANAPHYLAXIS IS MORE FREQUENT FOLLOWING PARENTERAL ADMINISTRATION, IT HAS OCCURRED IN PATIENTS ON ORAL PENICILLINS. THESE REACTIONS ARE MORE APT TO OCCUR IN INDIVIDUALS WITH A HISTORY OF SENSITIVITY TO MULTIPLE ALLERGENS. THERE ARE REPORTS OF PATIENTS WITH A HISTORY OF PENICILLIN HYPERSENSITIVITY REACTIONS WHO EXPERIENCED SEVERE HYPERSENSITIVITY REACTIONS WHEN TREATED WITH A CEPHALOSPORIN. BEFORE THERAPY WITH A PENICILLIN, CAREFUL INQUIRY SHOULD BE MADE ABOUT PREVIOUS HYPERSENSITIVITY REACTIONS TO PENICILLINS, CEPHALOSPORINS, AND OTHER ALLERGENS. IF AN ALLERGIC REACTION OCCURS, THE DRUG SHOULD BE DISCONTINUED AND APPROPRIATE THERAPY SHOULD BE INITIATED. SERIOUS ANAPHYLACTOID REACTIONS REQUIRE IMMEDIATE EMERGENCY TREATMENT WITH EPINEPHRINE, OXYGEN, INTRAVENOUS STEROIDS, AIRWAY MANAGEMENT, INCLUDING INTUBATION, SHOULD ALSO BE ADMINISTERED AS INDICATED.

Precautions

Prolonged use of antibiotics may promote the overgrowth of nonsusceptible organisms. If superinfection occurs during therapy, appropriate measures should be taken.

PREGNANCY: Pregnancy Category B. Reproduction studies have been performed in mice and rats at doses up to ten times the human dose and have revealed no evidence of impaired fertility or harm to the fetus due to cyclacillin. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

NURSING MOTHERS: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when cyclacillin is administered to a nursing woman.

Adverse Reactions

The oral administration of cyclacillin is generally well tolerated.

As with other penicillins, untoward reactions of the sensitivity phenomena are likely to occur, particularly in individuals who have previously demonstrated hypersensitivity to penicillins or in those with a history of allergy, asthma, hay fever, or urticaria.

The following adverse reactions have been reported with the use of cyclacillin: diarrhea (in approximately 1 out of 20 patients treated), nausea and vomiting (in approximately 1 in 50), and skin rash (in approximately 1 in 60). Isolated instances of headache, dizziness, abdominal pain, vaginitis, and urticaria have been reported. (See WARNINGS)

Other less frequent adverse reactions which may occur and that have been reported during therapy with other penicillins are: anemia, thrombocytopenia, thrombocytopenic purpura, leukopenia, neutropenia and eosinophilia. These reactions are usually reversible on discontinuation of therapy.

As with other semisynthetic penicillins, SGOT elevations have been reported.

Dosage and Administration

INFECTION*	ADULTS	CHILDREN
		Dosage should not result in a dose higher than that for adults.
Respiratory Tract		
Tonsillitis & Pharyngitis**	250 mg q.i.d. in equally spaced doses	body weight <20 kg (44 lbs) 125 mg q.i.d. in equally spaced doses body weight >20 kg (44 lbs) 250 mg q.i.d. in equally spaced doses
Bronchitis and Pneumonia		
Mild or Moderate Infections	250 mg q.i.d. in equally spaced doses	50 mg/kg/day q.i.d. in equally spaced doses
Chronic Infections	500 mg q.i.d. in equally spaced doses	100 mg/kg/day q.i.d. in equally spaced doses
Otitis Media	250 mg to 500 mg q.i.d. in equally spaced doses depending on severity	50 to 100 mg/kg/day in equally spaced doses depending on severity
Skin & Skin Structures	250 mg to 500 mg q.i.d. in equally spaced doses depending on severity	50 to 100 mg/kg/day in equally spaced doses depending on severity
Urinary Tract	500 mg q.i.d. in equally spaced doses	100 mg/kg/day in equally spaced doses

*As with antibiotic therapy generally, treatment should be continued for a minimum of 48 to 72 hours after the patient becomes asymptomatic or until evidence of bacterial eradication has been obtained.

**In infections caused by Group A beta-hemolytic streptococci, a minimum of 10 days of treatment is recommended to guard against the risk of rheumatic fever or glomerulonephritis.

In the treatment of chronic urinary tract infection, frequent bacteriologic and clinical appraisal is necessary during therapy and may be required for several months afterwards.

Persistent infection may require treatment for several weeks.

Cyclacillin is not indicated in children under 2 months of age.

Patients with Renal Failure

Based on a dosage of 500 mg q.i.d., the following adjustment in dosage interval is recommended:

Patients with a creatinine clearance of >50 ml/min need no dosage interval adjustment.

Patients with a creatinine clearance of 30-50 ml/min should receive full doses every 12 hours.

Patients with a creatinine clearance of between 15-30 ml/min should receive full doses every 18 hours.

Patients with a creatinine clearance of between 10-15 ml/min should receive full doses every 24 hours.

In patients with a creatinine clearance of <10 ml/min, serum creatinine values of >10 mg%, serum cyclacillin levels are recommended to determine both subsequent dosage and frequency.

CYCLAPEN® (cyclacillin) for oral suspension
125 mg per 5 ml:
100 ml and 200 ml bottles
250 mg per 5 ml:
100 ml and 200 ml bottles

Wyeth Laboratories
Philadelphia, Pa 19101



Donn L. Smith, M.D., of Tampa . . . has been appointed by the American Medical Association Board of Trustees to the United Stated Adopted Names (USAN) Council.

The Council, composed of representatives of the American Pharmaceutical Association, the Food and Drug Administration, AMA and other groups, recommends names for new drugs.

Dr. Smith is Professor of Pharmacology and former Dean of the University of South Florida College of Medicine.



Dr. Hodes

FMA President Richard S. Hodes, M.D., . . . will not pack away his gavel for good when he leaves office during the FMA Annual Meeting next May. In July, Dr. Hodes will assume the presidency of the National Conference of State Legislatures at its convention in New York.

The Conference, headquartered in Denver, Colo., represents the nation's 7,500 state lawmakers and their staffs.

Dr. Hodes has been a member of the Florida House of Representatives representing his Hillsborough County district for many years. He serves as Speaker Pro Tem this year after several years of service as Chairman of the House Education Committee and Health and Rehabilitative Services Committee.

Thirteen Florida Physicians . . . were elected Fellows of the American College of Physicians on November 10, 1979. Charles K. Donegan, M.D., of St. Petersburg, ACP Governor for Florida, identified them as:

Lee A. Bricker, M.D., David J. Kudzma, M.D., and Paul S. Swaye, M.D., all of Miami Beach; Phineas Hyams, M.D., Julio C. Pita Jr., M.D., and Howard W. Wallach, M.D., all of Miami; Edward W. Gotti, M.D., of Dunedin; and Istvan Krisko, M.D., of West Palm Beach.

Elliot G. Levy, M.D., North Miami Beach; Allen R. Sklaver, M.D., Plantation; David A. Solomon, M.D., Tampa; David R. Stutz, M.D., Sarasota; and Joseph Wanka, M.D., Fort Lauderdale.

According to Dr. Donegan, 1,569 Florida physicians were ACP members as of last August, a 33% increase since 1976.

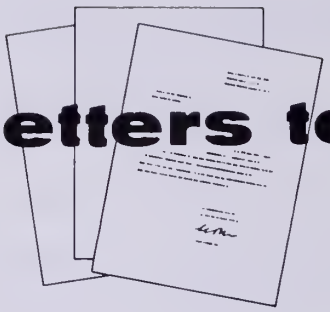
James L. Talbert, M.D., of Gainesville . . . has been elected a Florida Governor-at-Large of the American College of Surgeons. He was elected at the Annual Meeting of ACS Fellows on October 25, for a term ending in 1982.

Dr. Talbert is Professor and Chief of the Division of Pediatric Surgery at the University of Florida College of Medicine.

Gwendolyn S. Connor, M.D., of Winter Haven . . . has been elected Assistant Secretary of the American Society of Anesthesiologists.

Dr. Connor is Chairman of the ASA Committee on Membership and Credentials and has served as an officer of the Florida Society of Anesthesiologists for several years.

A graduate of the Medical University of South Carolina, Dr. Connor is a Diplomate of the American Board of Anesthesiology and is a member of the Polk County and Florida Medical Associations.



Letters to the Editors

RETAIN RECORDS

Harold W. Parham, D.H.A.
Executive Vice-President, FMA
Jacksonville

Dear Harold: Recently one of my doctor friends asked me how long doctors were expected to retain the records of patients who have ceased to return to the doctor for whatever reason or have died. It has been my custom to retain charts of patients who ceased to return for a period of five years, then discard them. For those who have died we have kept the records only three years. The radiologists in the Dade County area keep x-ray films on patients not more than five years and many discard them at the end of three years, I believe.

This letter is to inquire if there are any legal guidelines that specify how long patients records should be kept in the two instances noted above before discard.

One year I notified a group of patients that they could have their records if they would call for them, and only three or four responded to my notification, therefore I have ceased to do this. I will appreciate any information you can get me on this matter.

Sincerely,
William M. Straight, M.D.
Miami

William M. Straight, M.D.
Historical Editor
Miami

Dear Dr. Straight: This is in response to your letter of October 22, 1979 addressed to Dr. Parham, relative to the retention of medical records of patients who have ceased to return to you or have died.

In regard to patients who have ceased to return to you, it has been my advice that physicians retain those records for the maximum period of the Statute of Limitations. As you know, the current Statute of Limitations in Florida provides that a malpractice action may be commenced against a physician within two years from the date of the occurrence of the alleged malpractice or two years from the date of discovery by the patient, but in no event longer than four years from the date of the occurrence. This statute may be extended to seven years if the patient can show fraud or concealment by the physician relative to a problem the physician had knowledge of. Accordingly, I have recommended that records be maintained from the date of the last visit for a period of seven years.

In regard to patients who have died, I think the same advice is applicable since the representative of the estate of the deceased could commence an action on behalf of the estate within the same applicable time limits.

Should you have any questions regarding this, please do not hesitate to let me know.

Sincerely,
John E. Thrasher
FMA Legal Counsel

FOREIGN READERSHIP

To the Editor: Several days ago I was speaking with Dr. Charles Donegan, regarding a very brief article that was published in *The Journal of the Florida Medical Association*, in the June 1979 issue. It concerned an intra-articular accessory sesamoid dislocation of the great toe.

I had considered this a rather rare and miniscule article, but I was pleasantly surprised when I began receiving requests for reprints from Belgium, Czechoslovakia, Chicago, Philadelphia, and other foreign and United States locations. There have been none from Florida so far.

I commented that *The Journal* is certainly having an international readership and Charles thought that you both might be interested in knowing of this response.

Most Sincerely,
James C. Barnett, M.D.
St. Petersburg



Others Are Saying

Why Medicaid Has Spawned "Second Class" Medicine

Robert A. Goldstone, M.D.

A cruel hoax has been perpetrated by the Government upon the recipient of Medicaid. The Medicaid bureaucracy is doing its best to see that there will continue to be two levels of medical care, and that the Medicaid patient will remain a second class patient.

By way of historical background, the intent of the Medicaid law was to remove the medically indigent patient from the clinic setting, to abolish his (her) status as a "charity case," and to provide him (or her) the same quality of medical care that the paying public was assumed to be receiving. This was the promise of the program.

From the outset, the performance was hampered by restrictive regulations which, contrary to the intent of the program, made it impossible for a physician to treat a Medicaid patient in the same fashion that he would treat a private patient. For example, since Medicaid would not reimburse him for the cost of an expensive medication which he might inject, or for a device or appliance which he customarily dispensed, he was faced with the choice of either altering the method of dealing with that patient or his problem, or suffering a net loss with respect to reimbursement for that patient visit, if the cost of the material supplied exceeded the allowance paid by Medicaid.

That allowance in itself was far below the usual and customary fee the physician had been charging, which has been recognized by Medicare and other insurance agencies.

When the physician is prevented from choosing the same treatment for his Medicaid patients as he selects for his other patients, the Government has in fact established a "second class" medical system for the indigent. The patient is therefore thrust once more into the role of receiving "charity care" from the physician.

In addition, the program has become a bureaucratic nightmare. The paperwork is impossible. Every judgment is questioned and criticized, frequently by people with little or no medical knowledge. Hospitalized patients are suddenly denied benefits, and access to the appeals system is restrictive and time-consuming.

We have all read of "Medicaid Mills." Why do they exist? Because only by processing large numbers of patients and ordering large numbers of laboratory tests, and otherwise taking advantage of the loopholes and weaknesses in the Medicaid law is it possible to afford to treat other than an occasional Medicaid patient. A physician who lives in a community with a significant number of Medicaid patients, and who wishes to practice good, ethical medicine, finds it difficult to do so at the Medicaid reimbursement rate.

The public must be aware that a medical office can have a tremendous overhead. Only the work of the physician in the office produces income, yet there are one to four nurses, assistants, technicians, and receptionists, increasing rents, increasing heating and electrical bills, sky-rocketing insurance premiums for malpractice, and a host of other expenses which the patient generally does not stop to think about. The individuals to whom these bills are owed do not extend "charity" and are not concerned about whether or not the physician is treating Medicaid patients.

Recognizing that a crisis does exist, I would hope that some of the anger expressed at the medical

profession could be directed at the governmental agency which has ordered that care be provided, but failed to provide the necessary funds to pay for that care.

I am sure that if the Government promised poor and hungry people free milk, and arranged for it to be provided by dairies who would be reimbursed at the rate of $1 a gallon, well below the market value, there would be no dairies providing milk. The Government has done the same thing with Medicaid.

I have hesitated thus far to touch upon the even more sensitive aspect of a Medicaid practice. It would be easy to misconstrue my remarks as prejudicial, which they are not meant to be. For a variety of societal and economic reasons, it has been the experience in my practice that the following problems exist more frequently with Medicaid patients than with the balance of my patient population.

(1) There is a very high percentage of patients who seek medical attention for minor complaints and for problems that are self-limited and require no medical attention, for which paying patients would not think of calling a physician, and which do not require the attention of a physician.

(2) There is a significant higher percentage of "no-shows" in the Medicaid population than in the general population. A no-show represents an intolerable loss of productive time for a physician who is trying to work by a reasonable schedule.

(3) The Medicaid patient tends to bring with him more people (including children who remain unsupervised during their parent's examination, disrupting the office routine and tranquility), who utilize a disproportionate amount of the available waiting room space so that there is insufficient room for the remaining patients and visitors.

(4) There is a greater tendency not to follow the recommendations of the physician, which is a frustrating experience for the doctor, and which hampers rational delivery of health services.

Now I am certain that those who read this hastily will conclude that I am a bigot, against the poor, and a very prejudiced person. Personally, I believe that my liberal credentials are in order, and I would point out that not only do I practice in Paterson, New Jersey, which is overwhelmingly populated by minority groups, but also that I am about to move my office further into the heart of the downtown area.

It is necessary to point out that there is a tremendous problem involved in attempting to deliver high-quality medical care to patients who have never experienced it before, who hold different values, who are used to being treated like numbers instead of individuals, who are unable to find babysitters to watch their families when only one needs to be examined, and who are unable, by training and experience, to make even slightly sophisticated judgments regarding the necessity for obtaining health care and for following orders.

Couple these patients and problems in a significant percentage of the Medicaid population with a repressive system of reimbursement, which in fact can result in a payment to the physician of less than the actual cost of goods and services rendered to the patient, and it should be understandable why increasing numbers of physicians find it difficult to participate in the program.

By way of example, let me point out that in my locality, a specialist is reimbursed $7.56 for an office visit. If he provides an elastic bandage, crutches, or utilizes supplies for dressings, he is allowed no more money. The absurdity of this situation is apparent when the patient is referred instead to the hospital clinic. Reimbursement to the clinic is based upon a formula which takes into account the cost of providing care to that patient. Follow-up visits at the clinic at the hospital where I practice, which is a Catholic nonprofit hospital, are reimbursed at the rate of $35 per visit — and this figure is arrived at by taking into account the actual costs.

If a non-profit institution finds that it costs $35 to examine and treat a patient in a clinic setting, how can the Government justify payments of less than one quarter of that amount to the physician who renders personal care, in dignified surroundings, to that same patient with the same problem and with the same needs?

The answer is that it can't, but it finds it impossible to underpay hospitals, while they can expect paying patients to make up the difference in the doctor's office. When the saturation point is reached, that is, when the physician can no longer pass on his costs or absorb them, he is faced with the choice of either reducing his Medicaid practice (and these patients then return to the clinics at a four-fold *increased* cost to the Government!), or compromising his standards of care and creating a second level to comply with Medicaid imposed restrictions.

I believe that the Medicaid patient is entitled to the same "first class" medical care as the rest of my patients. If the Government holds out that promise to the indigent, it must be prepared to back it up. I join with all thoughtful people who condemn the abusers of the system, and ask that we all join in an effort to urge the Government to show that it intends to make it work, and fulfill its promise, which until now has been a hollow one.

Reprinted by permission from the April 1978 issue of MEDICAL MARKETING & MEDIA.

Dr. Robert Goldstone is a solo practitioner in Paterson, New Jersey.

Editorial Comment ..... James F. Richards Jr., M.D.

One of the obvious lessons of the foregoing article is that goods and services for which one pays nothing, generally unappreciated and fail to afford the recipient any lasting satisfaction. We are all aware of the manner in which such goods and property fall into disrepair for lack of maintenance. Medical services provided free fail to stimulate the recipient to contribute any positive effort to affect success of that service or treatment.

Further, we have in our own State of Florida used the term "second class citizen" numerous times in reference to third party sponsored patients. We have felt, for instance, that the Worker's Compensation Fee Schedule, which of course is below usual and customary fees, and the red tape in the care of Worker's Compensation patients, combine to create a group of citizens in our State who do not have access to all of the finest physicians in the State. Many physicians have been unwilling to care for injured workmen who do require more attention and time than most of our private patients, but whose third party carriers pay us less than our usual and customary fees. Of course, one of our arguments in the Worker's Compensation arena has been that we, of the FMA, do not feel that it is proper for the State to create a group of "second class citizens or patients."

America the Lovable

It has become unfashionable to say this; it may be embarrassing to hear it; but I believe that America is the most lovely and livable of all nations.

I believe that Americans are the kindest and most generous of all people.

I believe that there are no underprivileged Americans; that even the humblest of us are born with a privilege that places us ahead of anyone else, anywhere else; the privilege of living and working in America, of repairing and renewing America; and one more privilege that no one seems to get much fun out of lately — the privilege of loving America.

Al Capp

"I Can't Afford A 'B'"

Stewart G. Wolf, M.D.

Most present-day medical-school admissions committees eliminate from consideration all applicants whose transcripts fail to reflect a grade-point average within half a point of straight "A". This system simply means that the aspiring premedical student must select college courses that offer him a reasonable assurance of an "A" if he does well, he is therefore likely to select highly structured courses in which the questions have "right" answers. He must avoid such courses as philosophy and English literature, among many others in the humanities and fine arts. The result must surely be that nowadays those who are most comforatable with "other-directed" rather than "inner-directed" educational goals are most likely to be drawn into the study of medicine.

Lewis Thomas, in one of his delightful Notes of a Biology-Watcher, writes, "There is still some talk in medical deans' offices about the need for general culture, but nobody really means it, and certainly the premedical students don't believe it."* My concern is that we not only are bringing into medical school young men and women who lack a civilizing background in the humanities, who have read little and may have written not at all, but also are making medical-school admission easy for concrete thinkers, those who know how to learn only if the material to be learned is clearly laid out. We may thereby be barring from admission the reflective students, the creative, the original and those capable of critique and abstract thought.

With the characteristically human penchant for self-deception the faculty seems to find comfort in having selected a more or less pure culture of rapid learners. In fact, one often hears in the corridors that "we are getting brighter and brighter students in medical school." Are we really, or does our complacency derive from the fact that quantifiable criteria for admission to medical school protect the faculty and administration from the importunings of friends of friends and pressures from legislators? Are the clearly specified and hence readily defensible criteria for admission those most likely to yield a wise and cultivated doctor — a person capable of dealing with uncertainty, of compassionate understanding and wise judgment? Can such an ideal physician be expected from an intellectual forme frust who has spent his college years only learning the "right answers?"

Less structured college courses that depend on classroom discussion, individual intuitions, judgments and ideas may be needed to sharpen the student's perspective and to enable him to make discriminating judgments where there is no "right" and "wrong." The departments of English literature and sociology in one university offer a course in "The Sociology of Medicine." The students engage in classroom discussion, in reading and in writing essays. Each year most of the initial subscribers to the course are premedical students. Most of them drop it, however, before the grading deadline. "I enjoy the course," one said to me, "but I can't afford a 'B'."

The prevailing vogue for aptitude tests of all sorts, including "intelligence tests," has led many to think of intelligence in a undimensional way. There are, on the other hand, many manifestations of intelligence and many and varied expressions of talent that do not cluster in uniform fashion. Thus, a person capable of analytical thought and creative imagination may not be a rapid learner or vice versa. Furthermore, individuality and independent motivation may lead a student to put little effort into one college course and a great deal more into another, thereby adversely affecting his grade-point average.

Medical practice as well as medical research sorely needs minds capable of abstraction, capable of eliciting and dealing with data in an analytic fashion and of synthesizing information to useful ends. Moreover, the ability to deal with uncertainty is essential to effective medical practice, to the individualization of medical care and, of course, to the creative process in research. If consideration for admission to medical school had been governed by grade-point averages over a longer span of history we would surely have been denied the monumental contributions of Claude Bernard, "a poor student," and doubtless others who have contributed to the present state of development of medical science.

There is no available documentation that grades in college courses correlate closely with performance in medical school or in a medical career. In fact, some studies have found a lack of correlation. Nevertheless, medical schools persist in giving consideration for admission only to applicants whose grade-point average falls somewhere above the B level.

Perhaps it is time not only to reconsider premedical education as Thomas suggests but also to re-examine critically the validity of the criteria for admission to medical school.

The way in which academic institutions have come to address most problems in recent years implies a conviction that large committees afford more wisdom and discrimination than a few people or a single individual. Thus, as the number of applicants to medical school has risen, admission committees have become larger. They often talk of the need for "noncognitive" criteria and may try to provide them by wholesale interviewing. Forty years ago many medical schools left the job of selecting an entering class to one person, usually an associate dean who was identified as one with excellent antennae and capable of incisive judgments about people. Whether that method of selection was superior or not cannot be divined, but it certainly selected into medical school many who were not primarily grade-seekers and many of the highly prized role models whose numbers are dwindling fast.

To resurrect the contemplative "thinking doctor," the diagnostician of earlier years or the presently-sought-after general internist or primary physican may require a return to human judgment as the main determinant for admission to medical school rather than grade-point averages, aptitude tests and committee consensus.

● Dr. Wolf, St. Luke's Hospital, Bethlehem, Pa. 18015.

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*Thomas L.: How to Fix the Premedical Curriculum, New England J. Med. 298:1180-1181, 1978.

MARK THESE DATES

ON YOUR CALENDAR . . .

MAY 7-11, 1980

106TH ANNUAL MEETING

FLORIDA MEDICAL ASSOCIATION, INC.

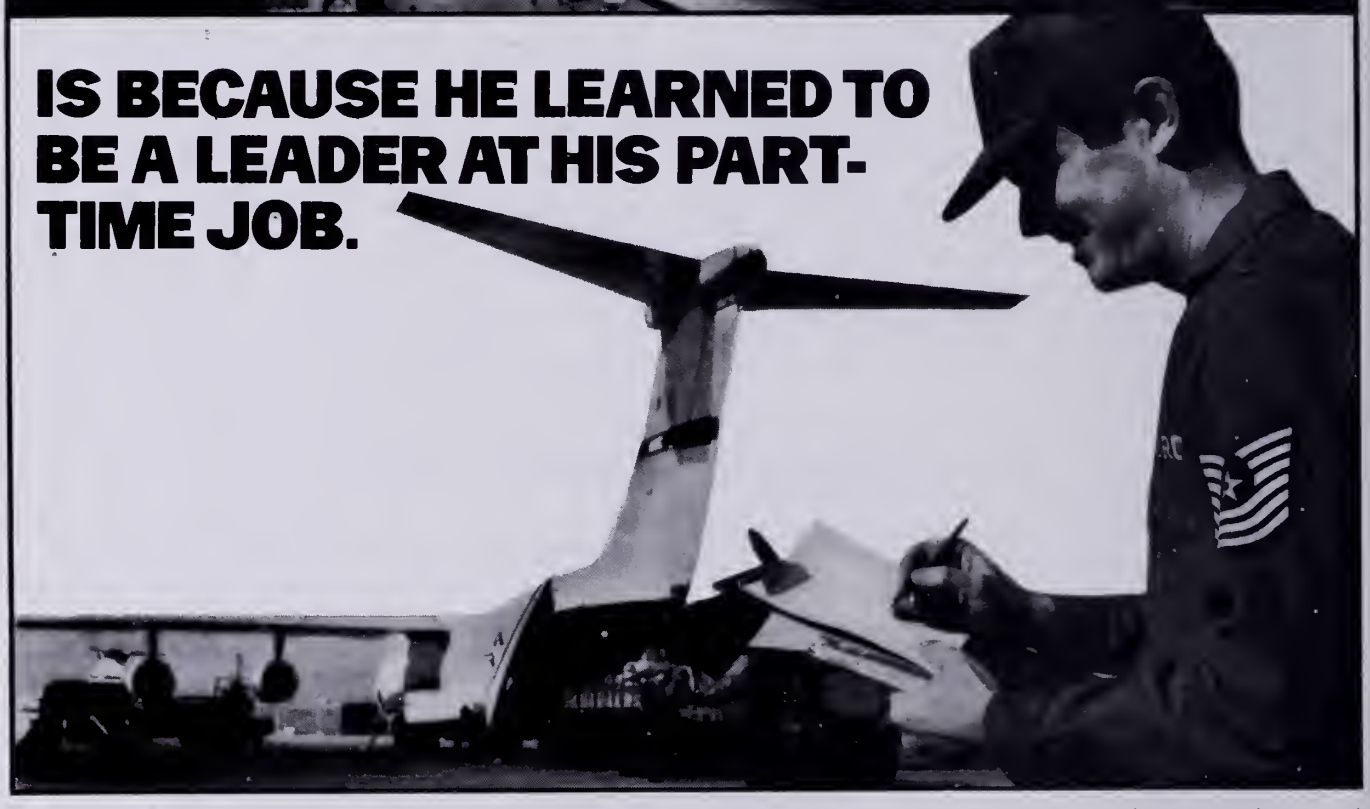
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ONE OF THE REASONS HE GOT TO BE A FOREMAN AT HIS FULL-TIME JOB...



IS BECAUSE HE LEARNED TO BE A LEADER AT HIS PART-TIME JOB.



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EGR
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Deaths

Bairnson, George Andrew, Bradenton; born 1892; University of Illinois, 1919; died November 16, 1979.

Brashear, Richard W., Naples; born 1903; University of Cincinnati, 1929; member AMA; died August 29, 1979.

Giammttei, Francis, Sun City Center; born 1900; Hahnemann Medical College, 1926; died July 19, 1979.

Grace, Charles C., St. Augustine; born 1905; University of Arkansas, 1931; died April 26, 1979.

Hellman, Daniel Steele, St. Petersburg; born 1933; St. Louis University School of Medicine, 1959; member AMA; died September 21, 1979.

Hutcheson, James B., Clearwater Beach; born 1922; University of Virginia School of Medicine, 1946; died September 3, 1979.

Jukofsky, Isidore, North Miami Beach; born 1899; Long Island College Hospital, 1923; member AMA; died 1979.

Kendrick, Odis Gilben, Tallahassee; born 1893; Chicago College M & S, 1916; member AMA; died May 24, 1979.

Lungerhausen, Carl Oscar, Sebring; born 1902; Jefferson, 1928; died July 1, 1979.

Marion, Donald F., Miami; born 1911; Duke University, 1936; member AMA; died July 10, 1979.

Morris, James, Jacksonville; born 1931; Medical College of Georgia, 1955; member AMA; died October 27, 1979.

Murphy, Edmond J., Gainesville; born 1936; University of Nebraska, 1968; died 1979.

Nystrom, Robert B., Coral Gables; born 1931; Northwestern University, 1957; died November 26, 1979.

Pace, Jerome Van Horne, Fort Myers; born 1896; University of Nebraska, 1921; member AMA; died August 11, 1979.

Parker, Martle Foy, Panama City; born 1905; Rush School of Medicine, 1935; member AMA; died August 16, 1979.

Paul, Earl Rupert, St. Petersburg; born 1922; University of Maryland, 1946; member AMA; died August 10, 1979.

Reinartz, Paul V., Clearwater; born 1896; University of Pennsylvania, 1954; member AMA; died December 28, 1978.

Serwer, Jesse James, Hollywood; born 1904; State University of New York, 1927; member AMA; died 1979.

Sylvester, Michael J., Sarasota; born 1941; George Washington University, 1967; died August 8, 1979.

Ware, Newton C., Orange Park; born 1916; University of Georgia, 1942; died November 18, 1978.

Woolsey, Fred Bertram, Jacksonville; born 1895; Tulane University, 1919; member AMA; died November 4, 1979.

Wynn, Robert Sylvanus, Jacksonville; born 1894; Emory University, 1915; member AMA; died September 30, 1979.



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MEETINGS

Approved by the FMA Committee on Continuing Medical Education

FEBRUARY

4th Annual Cardiovascular Symposium — Cardiovascular Pharmacology and Therapeutics, Feb. 1-2, Sheraton Sand Key, Clearwater Beach. For information: Donald R. Eubanks, M.D., 323 Jeffords St., Clearwater 33517.

Cardiology at the Dark Continent, Feb. 1-2, Busch Gardens, Tampa.+

Florida Society of Pathologists Annual Slide Seminar (Diagnostic Problems in Soft Tissue Tumors and GYN Pathology) plus a Seminar in Cardiovascular Pathology, Feb. 2-3, Konover Hotel, Miami Beach. For information: Morton Robinson, M.D., Mt. Sinai Hospital, 4300 Alton Rd., Miami Beach 33140.

"Imageology 1980" 18th Annual Seminar, Feb. 2-8, Fontainebleau Hilton, Miami Beach. For information: Lucy R. Kelley, c/o Miami Seminars, Box 343762, Coral Gables 33134.

12th Annual Postgraduate Seminar in Adult & Pediatric Urology, Feb. 6-9, Hotel Intercontinental, Miami. For information: Victor Politano, M.D., 6614 Miami Lakes Dr., East Miami Lakes 33014.

National Burn Seminar, Feb. 8-9, Gainesville Hilton, Gainesville.**

Family Practice Weekend, University of South Florida, Feb. 8-10, Holiday Inn, Airport, Tampa. For information: Frederick Firestone, M.D., Dept. of Family Medicine, University of South Florida College of Medicine, Tampa 33612.

Decision-Tree Approach to Diagnostic Radiology, Feb. 8-11, Dutch Inn, Lake Buena Vista. For information: Lucy R. Kelley, c/o Miami Seminars, Box 343762, Coral Gables 33134.

Gynecologic Oncology Seminar, Feb. 10-15, Royal Biscayne Beach Hotel & Racquet Club, Key Biscayne.*

Anxiety-A Clinical View, Feb. 13, Mount Sinai Medical Center, Wolfson Auditorium, Miami Beach. For information: Ms. Esther Cohen, CME Coordinator, Mt. Sinai Medical Center, 4300 Alton Raod, Miami Beach 33140.

***For information: Contact Division of Continuing Medical Education, D23-3, University of Miami School of Medicine, P.O. Box 016960, Miami 33101. Tel. (305) 547-6716.**

****For information: Contact Division of Continuing Education, Box J-233, J. Hillis Miller Health Center, Gainesville 32610. Tel. (904) 392-3143, or 392-3183.**

+For information: Contact Frank Cozzetto, M.D., CME, University of South Florida, Tampa 33620. Tel. (813) 974-2196.

Brief Therapy of Stress Response Syndromes, Feb. 14, Holiday Inn, Plantation. For information: Peggy Jackson, ACSW, 330 S.W. 27th Ave., Ft. Lauderdale 33312.

Glaucoma, Feb. 14-16, Holiday Inn, Civic Center, Miami.*

Otolaryngology for the Family Physician, Feb. 16-17, University of South Florida College of Medicine, Tampa. For information: James N. Endicott, M.D., University of South Florida College of Medicine, 12901 N. 30th St., Tampa 33612.

1st Annual Family Practice Update, Feb. 18-22, Daytona Beach. For information: Ken Mead, Post Office Box 1990, Daytona Beach 32015.

Nuclear Cardiology In-Service Workshop, Feb. 18-22, University of Miami, Jackson Memorial Medical Center, Miami.*

Medicine and Marriage Workshop (extension of Conference on the Beach: 1st Annual FP Update), Feb. 23, Daytona Hilton, Daytona Beach Shores, For information: Richard W. Dodd, M.D., Box 1990, Daytona Beach, 32015.

Florida Midwinter Seminar in Ophthalmology & Otolaryngology, Feb. 24-Mar. 1, Bahia Mar Hotel, Ft. Lauderdale.*

12th Teaching Conference in Clinical Cardiology, Feb. 27-Mar. 1, Americana Hotel, Bal Harbour.*

Advanced Conference on Family Therapy, Feb. 28-29, Central Florida Community College, Ocala. For information: Ralph F. Ranieri, 717 S.W. 16th Ave., Ocala 32670.

7th Annual Selected Topics in Urology, Feb. 28-Mar. 1, Gainesville Hilton, Gainesville.**

Pediatric Dermatology Seminar, Feb. 28-Mar. 2, Eden Roc Hotel, Miami Beach. For information: Guinter Kahn, M.D., 16800 N.W. 2nd Ave., Suite 401, North Miami Beach 33169.

Basic Life Support, Feb. 29, Pasco-Hernando Community College, New Port Richey. For information: James M. Marlowe, M.D., Box 249, Elfers.

EKG Interpretation and Arrhythmia Management, Feb. 29-Mar. 2, Sheraton Hotel, Ft. Lauderdale. For information: International medical Education Corp., Div. of Postgraduate Education, Dept. 12, 64 Inverness Dr., E., Englewood, CA 80112.

Ninth Annual Postgraduate Seminar in Dermatology, Feb. 29-Mar. 2, Carillon Hotel, Miami Beach.*

MARCH

Advanced Cardiac Life Support, Mar. 1-2, Pasco-Hernando Community College, New Port Richey. For information: James M. Marlowe, M.D., Box 249, Elfers, Florida 33531.

Oncology for Family Practitioner and Internist, Mar. 1-8, Caribbean Cruise.*

OB-GYN Caribbean Cruise, Mar. 2-8.*

Basic Neurology for Psychiatrists and Generalists, Mar. 3-7, Konover Hotel, Miami Beach.*

Internal Medicine Update '80, Mar. 3-8, Dutch Inn, Lake Buena Vista. For information: Barry E. Sieger, M.D., Director of Medical Education, Orlando Regional Medical Center, 1414 S. Kuhl Ave., Orlando 32806.

Postgraduate Medical Refresher Course, Mar. 3-14, Galt Ocean Mile Hotel, Ft. Lauderdale. For information: Donald R. Lannin, M.D., 832 Central Medical Building, St. Paul, MN 55104.

Mediclinics, Mar. 3-14, Galt Ocean Mile Hotel, Ft. Lauderdale. For information: Donald R. Lannin, M.D., 832 Central Medical Bldg., St. Paul, MN 55104.

Contact Dermatitis, Mar. 4, Boca Raton Community Hospital, Boca Raton. For information: John P. Kinney, M.D., Box 3167, West Palm Beach 33402.

Diagnostic Radiology for the Emergency & Primary Care Physicians, Mar. 5-9, Pier 66, Ft. Lauderdale. For information: W. T. Haeck, M.D., 3900 N.W. 79th Ave., Suite 469, Miami 33166.

6th Annual Virginia Apgar Seminar, Obstetric and Pediatric Anesthesia, March 7-9, Americana Hotel, Miami Beach. For information: Dept. of Anesthesia, Mt. Sinai Medical Center, 1200 N.W. 10th Ave., Miami 33136.

Critical Pulmonary Care, Mar. 8-9, University of South Florida College of Medicine, Medical Center Auditorium, Tampa. For information: Allan Goldman, M.D., Pulmonary Disease Section (111C), 13000 North 30th St., Tampa 33612.

15th Annual Postgraduate Course in Internal Medicine — 1980, Mar. 9-15, Americana Hotel, Bal Harbour.*

Problems in Rheumatology, March 12-15, Don CeSar Beach Resort Hotel, St. Petersburg Beach. For information: Bernard F. Germain, M.D., Division of Rheumatology, Dept. of Internal Medicine, University of South Florida College of Medicine, Tampa 33612.

Ob-Gyn Cruise Seminar, Mar. 12-24, Aboard the "DORIC".*

Orthopaedics for Family and Emergency Physicians, Mar. 13-15, Dutch Inn, Lake Buena Vista. For information: Allan W. March, M.D., Box J-222, JHM Health Center, Gainesville 32610.

14th Annual American Cancer Society Clinical Cytopathology, Workshop, Mar. 14-15, Eckerd College, St. Petersburg. For information: Ira Evans, M.D., c/o American Cancer Society, Pinellas County Unit, 1001 S. McDill Ave., Tampa 33609.

11th Annual Topics in Internal Medicine, March 20-22, Gainesville Hilton, Gainesville.**

6th Annual Postgraduate Seminar in I.V. and I.M. Dental Sedation, March 20-23, Americana Hotel, Miami Beach. For information: Dept. of Anesthesiology, Mt. Sinai Medical Center, 1200 N.W. 10th Ave., Miami 33136.

Oral and Maxillofacial Surgery Seminar, Mar. 22-23, Bal Harbour.*

Hepatobiliary Disease, Mar. 27-29, Americana Hotel, Bal Harbour.*

Critical Care Medicine 1980, Mar. 27-29, Dutch Inn, Lake Buena Vista. For information: Barry E. Sieger, M.D., Director of Medical Education, Orlando Regional Medical Center, 1414 S. Kuhl Ave., Orlando 32806.

Perinatology III, Current Trends in Maternal and Neonatal Care, Mar. 27-29, Hyatt House, Orlando.**

Current Clinical Concepts in Otolaryngology, Mar. 27-29, Americana Hotel, Bal Harbour.*

13th Annual Physicians Workshop in EKG, Mar. 29-Apr. 3, Mexico City, Mexico. For information: Henry J. L. Marriott, M.D., Rogers Heart Foundation, St. Anthony's Hospital, St. Petersburg 33705.

11th Family Practice Review, March 31-Apr. 4, Orlando Hyatt Hotel, Kissimmee.**

APRIL

The Clinical Approach to Exercise Testing, Apr. 10-12, Sheraton Sand Key, Clearwater. +

Cardiac Rehabilitation, Apr. 11-13, Hyatt House, Orlando. For information: International Medical Education Corp., Div. of Postgraduate Education, Dept. 12, 64 Inverness Dr. E., Englewood, CA 80112.

Echocardiography In-Service Workshop, Apr. 21-25, Jackson Memorial Medical Center, Miami.*

Endocrinology and Diabetes '80, Apr. 25-26, Dutch Inn, Lake Buena Vista. For information: Barry E. Sieger, M.D., Director of Medical Education, Orlando Regional Medical Center, 1414 South Kuhl Ave., Orlando 32806.

8th Annual Intensive Care Symposium, Apr. 25-28, Eden Roc Hotel, Miami Beach.*

Update on Inhalation Anesthesia — Progress and Concepts of the Past Decade, Apr. 26-27, Marriott Hotel, New Orleans, LA. For information: Warren W. Sears, M.D., 1717 North E Street, Suite 205, Pensacola 32501.

MAY

Principles of Cosmetics for the Dermatologist: 1980, May 1-3, Omni International Hotel, Miami. For information: Ms. Esther Cohen, CME Coordinator, Mt. Sinai Medical Center, 4300 Alton Rd., Miami Beach 33140.

Designing A Program for the Management of Arthritis, May 13, Manatee Memorial Hospital Auditorium, Bradenton. For information: Leonides Y. Teves, M.D. 706 39th St., W., Bradenton 33505.

Nuclear Medicine and Radioassay Training Seminar, May 26-30, Miami.*

Master Approach to Cardiovascular Problems — 8th Annual Conference, May 30-June 1, Contemporary Hotel, Disney World, Lake Buena Vista. For information: Yolanda Barcena, Department of Cardiology, P.O. Box 016960, Miami 33101.

JUNE

Bascom Palmer Eye Institute, Resident's Day, June, Miami.*

Annual Homecoming in Psychiatry, June, Miami.*

Cardiology for the Practitioner, June 4-6, The Breakers, Palm Beach.**

Fifth Annual Florida Suncoast Pediatric Conference, June 15-1 Sheraton Sand Key Hotel, Clearwater. For information: Donald Macdonald, M.D., 801 Sixth St., S., St. Petersburg 33701.

MKSAP-V (Internal Medicine Review) (American College Physicians), June 23-27, The Dutch Inn, Lake Buena Vista.**

JULY

Coronary Disease, Exercise Teastin, and Cardiac Rehabili tion, July 11-13, Orlando Hyatt, Orlando. For information: Int national Medical Education Corp., Division of Postgraduate Educatic Dept. 12, 64 Inverness Dr., E., Englewood, Colorado 80112.

5th Canadian Summer Workshop in EKG, July 19-22, Edmonto Alberta, Canada. For information: Henry J. L. Marriott, M.D., Roge Heart Foundation, St. Anthony's Hospital, St. Petersburg 33705.

AUGUST

Fundamental and Clinical Aspects of Internal Medicine, Au 1980.*

EKG Interpretation and Arrhythmia Management, Aug. 22-24 Dutch Inn, Lake Buena Vista. For information: International Medica Education Corp., Division of Postgraduate Education, Dept. 12, 6 Inverness Dr., E., Englewood, Colorado 80112.

18th Annual Seminar in Cardiology, Aug. 30-Sept. 6, Copenhagen, Denmark. For information: Henry J. L. Marriott, M.D., Rogers Heart Foundation, St. Anthony's Hospital, St. Petersburg 33705.

OCTOBER

Echocardiography In-Service Workshop, Oct. 20-24, University of Miami, Jackson Memorial Medical Center, Miami.*

MEDICAL MESSAGE
from the Florida Doctors

BODY MYSTERIES

It doesn't take long to learn to distinguish between a stomach growl indicating hunger and a rumble of contentment. Other bodily quirks, however, are not so easily explained.

Years of training qualify your doctor as an authority on such matters as bumpy tongues and cracking knees. Despite the relationship most people have with their doctors, they are a little hesitant to ask about such things as ridges on fingernails, dandruff or a cold nose.

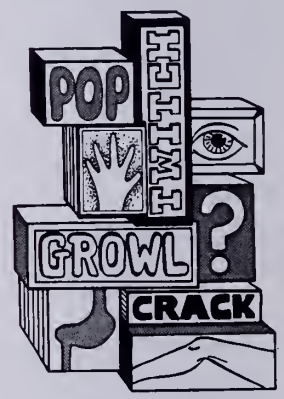
The minor tics and pains and peculiarities we all suffer are usually annoyances rather than real medical problems, but the doctors of Florida want patients to know the answers to questions — even when the questions don't get asked.

That little twitch or flutter you may have suffered in your cheek just below your eye is the result of an impulse discharged by a nerve which causes a muscle to quiver. It is not disease related.

How about foot cramps? Although regular foot cramps can be attributed to pathological conditions, most are called nocturnal cramps and can be relieved by massage or stomping. Similarly, those jerks of the leg that seem to occur just as you're drifting off to sleep are another muscle spasm that remains a mystery — and a minor nuisance.

Air and liquids being moved around in the stomach and intestinal tract are responsible for those embarrassing growls and rumblings. A high pitch gurgle is the result of air moving through a narrow passage, while a deeper sound comes from air being pushed through a larger channel.

Unless you suffer from one of about three rather rare diseases, the texture and color of your tongue is not a symptom of anything, according to Florida doctors.



If you hear ringing in your ears, it could be the result of several things — the doorbell, too much aspirin, or minor ear irritation. If the ringing is persistent, you should check with your physician.

Cold noses, hands or feet can be the result of poor circulation caused by constriction of small blood vessels near the surface of the skin or as a response to cold, but most often, it is an individual characteristic.

Dandruff, to some degree is perfectly normal, as are ridges in fingernails and hearing your own heartbeat.

If you have a question about your health, ask your doctor. He can provide you with answers.

This is a medical message from the Florida Medical Association on behalf of the doctors of Florida.

CLASSIFIED ADS

Physicians Wanted

FAMILY PRACTITIONER OR INTERNIST wanted to share facilities with three practitioners in solo practice. Major equipment provided. Rent $250 per month. Competent laboratory and x-ray departments with income based on use. Bookkeeping system and receptionist shared. Contact: T. C. Kenaston Jr., M.D., P.O. Box 550, Cocoa, Florida 32922.

MULTISPECIALTY GROUP OF PHYSICIANS located in North Florida seeking to expand in the following specialties: Rheumatology, Gastroenterology, Hematology/Oncology, Endocrinology and Infectious Diseases. Please send curriculum vitae to: C-928, P.O. Box 2411, Jacksonville, Florida 32203.

ORTHOPEDIST — Excellent opportunity for the right man in twenty physician multispecialty group in beautiful Northwest Florida beach community. Immediate incentive compensation plan with guarantee leading to full partnership. No investmet required. Ideal practice setting in new building located directly across the street from new modern hospital. Contact: Theodore D. Rahe, Administrator, White-Wilson Medical Center. Fort Walton Beach, Florida 32548. (904) 863-4121.

WANTED — Board qualified in Internal or Family Practice Medicine to associate with Dr. H. M. Silberman, 470 Biltmore Way, Coral Gables, Florida. Call (305) 443-3001.

INTERTISTS — PEDIATRICIANS — TAMPA BAY AREA — FLORIDA — Prepaid Health Care, a federally qualified HMO, has immediate openings for Internists and Pediatricians to complete the staffs of its St. Petersburg and Clearwater Ambulatory Care Facilities. Competitive salary and liberal fringe benefits with opportunity to participate in academic programs available. If interested, contact: Jerry S. Williamson, M.D., Medical Director, 1417 South Belcher Road, Clearwater, Florida 33516. (813) 535-3474.

EMERGENCY PHYSICIANS for position with young expanding group. Liberal salary package. Send CV to I. Bloomfield, M.D., Medical Director, P.O. Box 160132 Snapper Creek Station, Miami, Florida 33116 or call (305) 596-2896.

MEDICAL EMERGENCY SERVICE ASSOCIATES (MESA), S.C., now hiring qualified physicians to staff emergency departments in Florida. MESA offers excellent salary, working conditions, flexible scheduling and fringe benefits, plus the opportunity to join a stable, growing cooperation dedicated to providing quality emergency medical services. Send your C.V. or telephone: MESA, Florida, P.O. Box 8585, Orlando, Florida 32856 or Ms. Tesla (305) 841-5111, ext. 5898. MESA would like to be a part of your future.

STUDENT HEALTH CENTER SEEKING INTERNISTS to serve as consultant/staff physician with five GP and one GYN. Position available April 1980. Regular hours, malpractice insurance provided. Florida license required. Excellent climatic, cultural and fringe benefits. Send CV to: Director, University Health Center, Florida State University, Tallahassee, Florida 32306. Affirmative Action/Equal Opportunity Employer.

WANTED: Primary care and subspecialty physicians to join multispecialty group in South Palm Beach County. Excellent facilities. Compensation includes possibility of ownership in P.A. Send CV to P.O. Box 23606, Oakland Park, Florida 33334.

ANESTHESIOLOGIST NEEDS ASSOCIATE/PARTNER: Excellent opportunity in northwest Florida coastal community to join established anesthesiologist in productive practice. 234-bed modern, well-equipped hospital. Second new hospital under construction. Beautiful setting, good schools, solid economy. Write C-957, P.O. Box 2411, Jacksonville, Florida 32203.

STUDENT HEALTH CENTER is seeking primary care physician or gynecologist interested in consideration for future expected vacancy in gynecology clinic. Florida license required. Malpractice insurance provided. Regular hours. Excellent cultural, climatic, recreational and fringe benefits. Send CV to Director, University Health Center, Florida State University, Tallahassee, Florida 32306. Affirmative Action/EOE.

PHYSICIANS — NEED A CHANGE OF LIFE STYLE? OR A NEW PRACTICE SITUATION? One of our hundreds of openings nationally is probably the one you are looking for! We confidentially match your geographical, financial, and practice requirements to our many openings and give you detailed information on the practice situations that meet your requirements. There is no charge or obligation to you. Call Durham Medical Search, 717-M Statler Office Building, Buffalo, N.Y. 14202. (716) 852-5911.

FAMILY PRACTITIONER OR PRACTITIONERS, central Florida. Solo practice or salary guarantee with percentage and fringe benefits. 320 Parkview Place, Lakeland, Florida 33801. (813) 682-4913.

Situations Wanted

SITUATION WANTED: OB/GYN, 28, U.S. schooled and trained, seeks group or partnership position on East coast. Will consider all offers. Write C-943, P.O. Box 2411, Jacksonville, Florida 32203.

FAMILY PHYSICIAN wishes to buy practice or join group in Broward area. Curriculum Vitae on request. B. Reiter, 136 Roger Pilon, D.D.O., Quebec, Canada H9B 2B6. Telephone (514) 683-2765, in Florida (305) 454-4071.

OPHTHALMOLOGIST, 32, glaucoma fellowship, Board Certified, ECFMG, FLEX, seeking solo, association, group practice, East or West coast. Contact J. Sani, M.D., 1706 Exeter Avenue, Middlesboro, Kentucky 40965.

POSITION WANTED: Cardiologist Internist, 31, ABIM certified, University trained invasive and noninvasive cardiology, seeks solo or associateship. Available July 1980. George B. Ghanem, M.D., 39030 Pinebrook, Sterling Hts., Michigan 48078. Phone (313) 979-2848.

CEL BARRAMEDA, M.D. wants full time position, Nursing Home physician. Diplomate of American Board of Family Practice and has permanent Florida licensure. Age 50, prefers near shoreline. Telephone (414) 351-4306 or write to Celedonio C. Barrameda, M.D., 7521 North Beach Drive, Fox Point, Wisconsin 53217.

PULMONARY INTERNIST — ABIM and pulmonary board certified desires relocation to Florida. Seeks solo or hospital-based position with clinical and teaching responsibilities. Available immediately. Reply to C-958, P.O. Box 2411, Jacksonville, Florida 32203.

GENERAL SURGEON, 33, Board certified AOA, University trained, seeks solo or associate practice. Please reply to P. Gold 8296/16, Lever Bros., 390 Park Avenue, New York, N.Y. 10022.

MEDICAL ONCOLOGIST: Florida licensed. Ten years experience, wishes to relocate in south or central Florida. All opportunities will be considered. Write P.O. Box 8587, Jacksonville, Florida 32211.

GENERAL INTERNIST/GASTROENTEROLOGIST, 28, university trained, seeks partnership, group or solo in coastal Florida. Richard Weber, M.D., 4903 David Court, Cincinnati, Ohio 45215. Phone: home (513) 821-9432; business (513) 872-3100.

Practices Available

TWO MAN OFFICE ON ANNA MARIA ISLAND needs high quality Family Physicians. New building, fully equipped with lab and x-ray. Exceptional opportunity for ownership. Contact E. P. Dickerson, M.D., 2010 — 59th St., W., Bradenton, Florida 33505 or call collect (813) 792-2211.

RADIOLOGY — Successful office practice for transfer; resort area of Naples, Florida 33940. Radiology services, 960 Central Avenue (813) 261-1121.

Equipment

FOR SALE — Olympus fiberoptic bronchoscope. Used two times. All attachments. Excellent condition. Marked savings. Contact L. C. Taylor, M.D., 320 Parkview Place, Lakeland, Florida 33801. Phone (813) 682-4913.

FOR SALE: Hamilton power examining table in excellent condition. Price $1400. Please call (305) 365-6681.

Real Estate

OUTSTANDING LOCATION FOR SPECIALISTS: St. Nicholas Medical Center. Central location, off street parking and all utilities furnished (including janitor service). Contact W. G. Allen Jr., Owner-Manager, St. Nicholas Medical Center, 3127 Atlantic Boulevard, Jacksonville 32207. Phone: (904) 398-5500.

BREVARD COUNTY (Cape Kennedy Area). Several outstanding office suites for lease and/or sale in Cocoa, Cocoa Beach, Titusville, and Melbourne. Can be tailored to individual or clinical needs. Contact: Trend Realty, Inc., Realtors, P.O. Box 39, Cocoa Beach, Florida 32931. Attention: Dudley Hain, Realtor-Associate, (305) 783-8686.

BUILDINGS FOR LEASE — REMODEL or will build to suit your specifications. Across street from large complete hospital. Contact L. C. Taylor, M.D., 320 Parkview Place, Lakeland, Florida 33801, Phone (813) 682-4913.

LAKELAND, FLORIDA: FOR SALE, 6% down. Air conditioned office for one to three physicians, Main street, 168 x 140 ft.; double parking lots; extra cottage. Dr. L. Polskin, Box 15966, Honolulu, Hawaii 96815.

JACKSONVILLE 1,500 square feet, medically designed office. A/C; ample parking; stable, middle income residential community in N.W. Jacksonville. Some equipment available. Start at $250 per month. (305) 446-4284.

VENICE, FLORIDA — FOR LEASE: 15,000 square feet. Available in modern professional office building, the Venice Medical Plaza, located directly across from Venice Hospital. Venice, 18 miles south of Sarasota, on Florida's Gulf Coast, is one of the Nation's fastest growing areas. Ideally situated for physicians, dentists, clinics, and health-related associations or businesses. Medical suites finished to specifications. Interior parking. Business-like management. Attractive lease rates offered. Contact Venice Medical Properties, LTD., 530 South Nokomis Avenue, Venice, Florida 33595, or call (813) 485-1960.

RENT — LEASE — OR OWNERSHIP: 15,000 sq. ft. in medical-professional building, Orlando, Florida, includes 4,000 sq. ft. medical facility. Fully equipped laboratories, x-ray unit, examining rooms, offices and reception areas. Flexible terms. New deluxe construction adjacent to hospital complex. Call (305) 425-2843 24 hours or write Key Professional Bldg., 100 West Columbia St., Orlando, Florida 32806.

MOVING TO OCALA? Medical building for sale in Ocala, Florida. 8,200 sq. ft., 5 years old, unique architecture, lead x-ray room, between two hospitals.

Classified Advertising Rates Increase Effective January 1

***The Journal's* classified advertising base rate will increase from $7.50 to $10.00 for the first 25 words or less, effective January 1, 1980. The additional wordage rate of 25 cents per word remains unchanged. New rates for display advertising, also effective January 1, are available upon request.**

Completely leased. Good investment, priced at $560,000 with 29% down or make offer. Joyce Moody, Salesman Res. (904) 629-3747 or John J. Piccione, Real Estate, Inc., 2941 N.E. 3rd St., Ocala, Florida 32670.

NAPLES, FLORIDA — 2,035 sq. ft. of medically designed partitioned office space for one-three physicians; proximity to hospital. Call (813) 261-0161.

FOR RENT: Medical office, furnished or unfurnished. Suitable for two physicians. Across the street from hospital. 320 Parkview Place, Lakeland, Florida 33801. (813) 682-4913.

Art

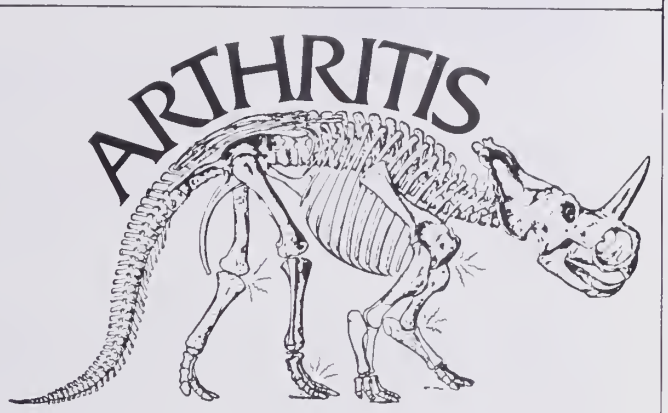
FINE ART. Major paintings by modern and contemporary masters. DeKooning, Johns, Kelly, Lichtenstein, Louis, Oldenburg, Pollock, Rauschenberg, Twombly, Warhol and others. By appointment only. Marvin Ross Friedman & Co., 15451 Southwest 67 Court, Miami, Florida 33157. (305) 233-4281.

Classified advertising rates are $10.00 for the first 25 words or less and 25 cents for each additional word. Deadline is first of month preceding month of publication.

The Florida Medical Association offers placement assistance through the Physician Placement Service, P.O. Box 2411, Jacksonville, Florida 32203. This service is for the use of physicians seeking locations, as well as physicians seeking associates, and is without charge.

THE FLORIDA GROUP INTERNATIONAL DOCTORS IN ALCOHOLICS ANONYMOUS meets regularly each one to two months. Further details are available from the Secretary, 2111 South Osprey, Sarasota, Florida. Phone (813) 366-6133.

MEDICAL MESSAGE
from the Florida Doctors



Examination of dinosaur bones is evidence that arthritis existed thousands of years ago and plagued these prehistoric creatures. Today, the painful disease continues to affect millions of Americans of all ages.

Independent research has gained more knowledge about arthritis in the past 10 years than the sum total of information gathered in the preceding 10 centuries. Arthritis exists in many forms, and while a positive cure has not been found, medical treatment to reduce pain and suffering is available to all.

The most common form of the disease is rheumatoid arthritis. It usually strikes people between the ages of 20 and 45, while osteoarthritis usually afflicts older people. Over $300 million is spent each year on worthless remedies while simple medical treatment is the only means of gaining relief.

An exact cause of arthritis is not known, but physicians advise steps that can help reduce your chances of becoming a victim. You should avoid physical stress and strain, excessive fatigue, overexposure to damp and cold, joint injuries, and neglect of chronic infections. Overweight, poor posture and occupational stress may also make you susceptible.

Persistent pain or stiffness on arising may be an early warning of arthritis, as are the symptoms of pain or tenderness or swelling in at least one joint, or redness in the area of at least one joint. Check with your physician if you suspect arthritis.

Since it is a disease known for its "ups and downs" you may trick yourself into thinking your ailment was only temporary.

This is a medical message from the Florida Medical Association in behalf of the doctors of Florida

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ROCHE

For recurrent attacks of urinary tract infection in women

Bactrim™ DS Double Strength Tablets



Each tablet contains 160 mg trimethoprim and 800 mg sulfamethoxazole.

Just one tablet b.i.d. for 10 to 14 days

- Action at urinary/vaginal/lower bowel sites helps eliminate reservoirs of infecting organisms
- Distinctive antibacterial action plus wide spectrum helps eradicate recurrent UTI
- Low incidence of bacterial resistance in community practice
- Convenient *b.i.d.* dosage provides day-and-night antibacterial control
- Contraindicated during pregnancy and the nursing period. During therapy, maintain adequate fluid intake; perform CBC's and urinalyses with microscopic examination.

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* **It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination.** *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register,* 37:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

Pneumocystis carinii pneumonitis: Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets,* each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. *Tablets,* each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. *Oral suspension,* containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

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Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Please see back cover.

BA-14-N

Her next attack of cystitis may require

the Bactrim™ 3-system counterattack



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Bactrim has shown high clinical effectiveness in recurrent cystitis as a result of its wide spectrum and distinctive antimicrobial action in the urinary, vaginal and lower intestinal tracts.

The probability of recurrent urinary tract infection appears to be enhanced by the establishment of large numbers of *E. coli* or other urinary pathogens on the vaginal introitus. The trimethoprim component of Bactrim diffuses into vaginal fluid in effective concentrations, thus combating migration of pathogens into the urethra.

Studies have shown that Bactrim acts against *Enterobacteriaceae* in the bowel without the emergence of resistant organisms. Thus, Bactrim reduces the risk of intr colonization by fecal uropathogens. It has *no* significant effect on other normal, necessary intestinal flora

Bactrim fights uropathogens in the urinary tract/vaginal t trac

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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION INC

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FEBRUARY 1980 • VOL 67 • NO. 2



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SPECIAL ISSUE ON PATHOLOGY

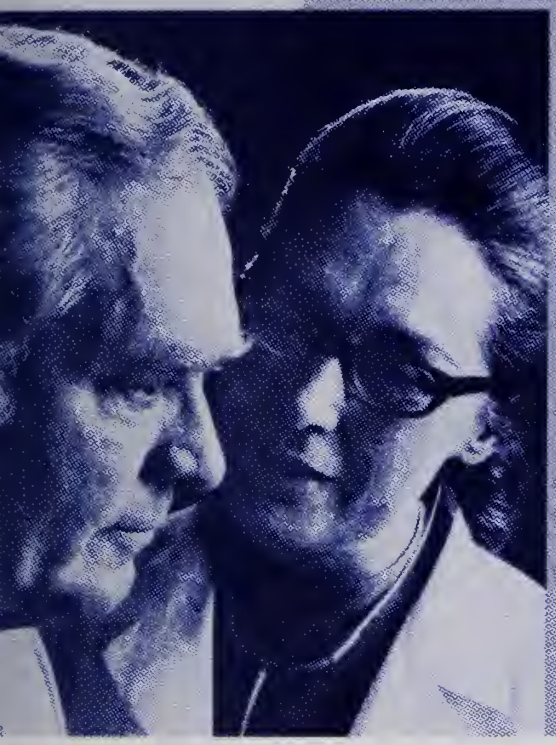
GUEST EDITORS
Laudie E. McHenry, M.D. and Pablo Enriquez, M.D.



proven antianxiety

Highly specific calming action virtually free of unwanted side effects: this was the remarkable clinical promise of Librium (chlordiazepoxide HCl). And today this promise continues to be fulfilled in a wide variety of patients you see every day.

ROCHE



The published record on Librium is enormous. So large, in fact, it had to be put into a computer data bank and retrieval system. It's a record that shows Librium is highly effective in relieving anxiety; that Librium is seldom associated with serious side effects; that Librium rarely interferes with mental acuity at proper doses; that Librium is used concomitantly with primary medications. However, as with all CNS agents, patients should be warned against hazardous activities requiring complete alertness, and about possible combined effects with alcohol.

performance

Librium® Ⓒ IV
chlordiazepoxide HCl/Roche



5mg, 10mg, 25mg capsules

synonymous with relief of anxiety

- ☐ An unsurpassed safety record
- ☐ Minimal effect on mental acuity, in proper dosage
- ☐ Predictable patient response
- ☐ Is used concomitantly with primary medications, such as anticholinergics and cardiovascular drugs

Please see next page for summary of product information.

Librium® 5mg, 10mg, 25mg capsules
chlordiazepoxide HCl/Roche

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral–Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*, severe states, 20 or 25 mg *t.i.d.* or *q.i.d. Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

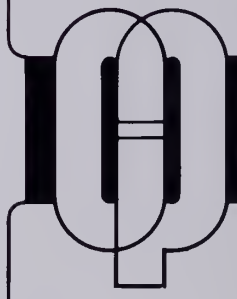
Supplied: Librium® (chlordiazepoxide HCl) *Capsules*, 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Libritabs® (chlordiazepoxide) *Tablets*, 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

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The primary beneficiaries of ORAL HYDERGINE®TABLETS, 1 mg (1 tab t.i.d.)

Each 1 mg Hydergine tablet contains dihydroergocornine mesylate 0.333 mg, dihydroergocristine mesylate 0.333 mg, and dihydroergocryptine (dihydro-alpha-ergocryptine and dihydro-beta-ergocryptine in the proportion of 2:1) mesylate 0.333 mg, representing a total of 1 mg.

They're in their late sixties, the beneficiaries of more liberal retirement laws and more enlightened attitudes toward the elderly. They're leading socially productive lives. But recently, without any clear cause, they had each begun to experience mild episodes of symptoms such as confusion, mood-depression, and dizziness. Their ability to function could have been jeopardized. That's when they became the beneficiaries of oral Hydergine therapy.



The still-functioning geriatric can benefit from Hydergine treatment

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We are indebted to Dr. Laudie E. McHenry and Dr. Pablo Enriquez, both of Melbourne, and the Florida Society of Pathologists for bringing this special issue to our readers. We are also most grateful to the authors and contributors to this issue of The Journal. (See contents on opposite page)

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FROM THE EDITOR'S DESK

CARTER BILL DEFEATED

Health providers have assured Congress that the Voluntary Effort to control health care costs will continue. "We renew our pledge to the American People and President Carter to fight inflation with every resource at our command," said AMA Executive Vice President James H. Sammons, M.D. Dr. Sammons' statement came on the heels of a lopsided 234 to 166 vote by which the House crushed the Carter Administration's hospital cost controls bill. The Administration had promoted the bill with fervor, calling it an essential prelude to National Health Insurance. In place of the Administration bill, the House voted to establish a Commission on Hospital Costs to report to the President on the success of the Voluntary Effort.

WORKERS' COMPENSATION

No one showed up at a hearing in Tallahassee in December to protest FMA's petition for an increase in the state Workers' Compensation fee schedule. FMA witnesses included President Richard S. Hodes, M.D., of Tampa; Chairman James F. Richards, M.D., of Orlando, of the Committee on Workers' Compensation; and staff member John Richardson of Jacksonville. FMA petitioned for a 35% across-the-board boost.

X-RAY TECHNICIANS

A decision was awaited last month regarding a proposed delay in the implementation of new x-ray technician requirements for certification enacted by the 1978 Florida Legislature. FMA planned a meeting with officials of the Department of HRS to discuss postponement on the basis that rules for certifying basic technicians go far beyond legislative intent. In preliminary discussions state officials indicated concern over the possibility that the regulations are too stringent and would inflate health care costs in Florida.

CAMPAIGN CONTRIBUTIONS

A three-year-long administrative proceeding over the issue of campaign contributions has come to an end with a conciliation agreement between the American Medical Political Action Committee (AMPAC) and the Federal Elections Commission (FEC). The agreement stemmed from a complaint by Common Cause to the FEC. Common Cause charged that in the 1976 and 1978 elections, AMPAC and political committees "connected with" state medical association made separate contributions to candidates which in the aggregate exceeded the $5,000 limit allowed by law. The conciliation agreement involved no admission of guilt by AMPAC and no fine was imposed. But AMPAC agreed to the FEC interpretation that in the future AMPAC is "affiliated" with state political action committees within the definition of "affiliated" in the election law.

PROGRESS IN HEALTH

In her annual report to Congress, HEW Secretary Patricia Harris said the United States made great strides in health in the 1970s. Secretary Harris's report shows a large decrease in the death rate for males and females in all age groups. Death from heart disease was down 17%, and the infant mortality rate dropped from 20 to 14.1 per 1,000 births. Life expectancy was extended over the 10 years from 70.9 years to 73.2.

OPINION

Recent polls show that physicians and the public agree that cost is the number one health problem in the country today. Surveys commissioned by the AMA indicate that two-thirds of the public and a little over half of the physicians regard cost as the major problem. Also, two-thirds of the public feel there is a need for National Health Insurance, although only 38% of the physicians perceive such a need. Other findings included: 88% of the public are "very or fairly satisfied" with their medical care; only a third of the public would approve of being treated by a group of physicians as opposed to a personal physician in an effort to contain costs, but almost half would approve of seeing a trained assistant for certain problems.

CHILD HEALTH BILL

The U.S. House of Representatives has passed the Child Health Assurance Act of 1979. The bill would bring about 1.1 million additional children and pregnant women into Medicaid eligibility. Among other things, the bill broadens health care benefits provided to Medicaid children, increases the proportionate share of the costs of health assessments and outpatient treatment for these children which is paid for by the Federal Government, and provides incentives for operation of more health assessment, outreach and follow-up programs by the states. Main stumbling block to passage was coverage of family planning services to minors and possible Medicaid funding of abortions. The bill may run into some difficulty in the Senate.

NATIONAL HEALTH INSURANCE

The AMA House of Delegates, at its interim meeting in Hawaii, has reaffirmed the Association's policy on National Health Insurance. The AMA Board of Trustees is authorized to sponsor, only if necessary, legislation requiring minimum standards of adequate benefits for health insurance policies, with deductible and co-insurance; including a system of uniform benefits provided by federal, state and local governments for those who cannot provide for their own medical care; making catastrophic insurance coverage, with deductible and coinsurance, available from the private insurance industry through a nationwide program; and providing for administration at the state level with national standardization through federal guidelines.

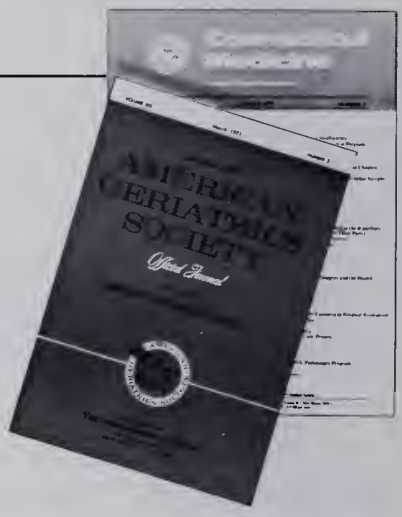
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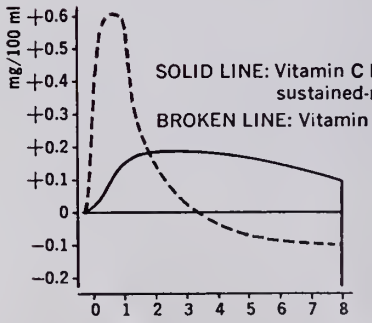
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1. Riccitelli, M.L.: Vitamin C Therapy in Geriatric Practice, J. Amer. Geriatrics Soc. 20:34, 1972
2. Riccitelli, M.L.: Vitamin C—A Review. Conn. Med. 39:609, 1975

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Summary of the FMA Board of Governors Meeting January 12, 1980

The following is a summary of the actions taken by the Board of Governors at its meeting on January 12, 1980.

THE BOARD:

CME Program

Approved a centralized and computerized CME program for the FMA similar to that of the Pennsylvania Medical Society with reporting forms to be processed directly by the FMA. Delinquencies will be sent to the county medical societies for review and return to FMA. The Board also approved modification of the CME suspension and appeals procedures to provide for a delinquent date of April 1 and a suspension date of October 31, unless compliance is demonstrated by that date.

Under the modified procedures, all physicians who were delinquent as of December 31, 1979, and subject to suspension March 15, 1980, are granted an extension until October 31, 1980 to satisfy their CME requirements.

A recommendation for exemption for full-time faculty members from reporting CME was referred to the Council on Scientific Activities for consideration.

Directed that County Medical Societies be advised that while a budget provision has been made for implementation of this program, cost factors may necessitate a dues increase.

FMA Journal Editor

Unanimously and enthusiastically approved the President-Elect's nomination of Daniel B. Nunn, M.D., of Jacksonville, to serve as Editor of the Journal for 1980-1981. Doctor Nunn will replace Dr. Gerold L. Schiebler whose term expires in May of 1980 after having served five years as Editor. The Board commended Dr. Schiebler for his extraordinary efforts and accomplishments in enhancing the quality and readership of the Journal during his tenure as Editor.

FMA Awards

Certificate of Merit

Selected a physician to be nominated to the House of Delegates as recipient of the Association's highest honor, the Certificate of Merit for 1980.

A. H. Robins Award, Distinguished Layman, Certificate of Appreciation

Selection of a physician as recipient of the 1980 A. H. Robins Award, the Distinguished Layman Award, and nomination of a physician to the House of Delegates for the Certificate of Appreciation was deferred until the March Board meeting. County Medical Societies wishing to submit additional nominations for these awards should do so at the earliest possible date.

AMA Nominations

AMA Councils and Committees

Enthusiastically supported the nominations of Robert E. Windom, M.D., for consideration of appointment to the AMA Council on Legislation and Rufus K. Broadaway, M.D., to the Council on Long Range Planning and Development.

AMA Thomas G. Sheen Award

Nominated Gerold L. Schiebler, M.D., Gainesville, to the AMA Board of Trustees as the recipient of the AMA Thomas G. Sheen Award for 1980 in recognition of his outstanding contributions in medicine.

AMA Accreditation Program

Went on record as officially supporting the AMA's CME accreditation activities and FMA's participation in these activities.

Florida Regional Association of Blood Service Units

Approved FMA's participation as a member in the Florida Regional Association of Blood Service Units. Among the purposes of the organization are: a) to foster cooperation with blood programs of the Florida Association of Blood Banks

and other blood service systems in promoting adequate supplies of voluntarily donated blood to meet the needs of the people of Florida; b) to monitor, promote and coordinate blood service activities including collection, distribution, inventory, management and public education; c) achieve maximum effectiveness in the procurement and distribution of blood and cooperate with other regional Associations, the American Blood Commission and other national and federal programs.

CME Symposium

Approved FMA's co-sponsorship of the CME Symposium to be conducted by McMaster University/University of New York to be held at the Sarasota Hyatt House in Sarasota February 29-March 2, 1980.

Avis Discount Rental Car Program

Approved renewal for 1980 of the Avis discount rental car program which will provide a 30% discount to physicians. This is a 5% increase in the discount allowed under the previous program. Additional details will be included in the next FMA Briefs to the membership.

FMA Defense Fund

Approved financial assistance from the FMA Defense Fund in the amount of $2,000.00 which is the maximum allowed under the program, to assist Dr. Antonio Frexes in his medical malpractice countersuit.

FMA Annual Meeting

Supported the proposal of the American Medical Woman's Association to sponsor a luncheon or dinner for women M.D.'s at the May 1980 Annual Meeting for the purpose of fostering interest in medical organizational activities by women M.D.'s and authorized publicity for this function in FMA annual meeting newsletters.

Lawsuits

Worker's Compensation

Received a report from FMA Legal Counsel on a petition filed on December 10, 1979, requesting an increase in the level of reimbursement to physicians for services under worker's compensation. Following the public hearing at which FMA representatives testified, additional time was allowed by the hearing officer for written comments. In compliance with the law, a ruling on the petition must be rendered within 90 days.

Department of Professional Regulations

Directed that the FMA institute a "friendly lawsuit" against the Department of Professional Regulations challenging the requirement that physicians display information in their offices where patients may complain as to services rendered.

AMA Delegates

Southeastern Coalition

The Board at its meeting in October authorized FMA's participation in the Southeastern Coalition for one year subject to Florida's AMA Delegates concurring. The Board received a report that the delegates voted unanimously to participate beginning with the 1980 AMA Annual Meeting, advising that it was the delegates feeling that many positive gains could be derived from a cooperative effort in addressing the many issues coming before the AMA House of Delegates. The Coalition includes the following states: Alabama, Delaware, Georgia, Louisiana, Mississippi, South Carolina, North Carolina, Maryland, Virginia, Florida and the District of Columbia.

AMA Membership

Expressed concern with the continuing decline in AMA membership which now stands at less than 50% of the country's physician population. It was noted that at the current rate of inflation, unless there are dramatic increases in membership, AMA expenses will exceed income by 1981. The Board requested the AMA Delegates to provide a summary of proposals currently being studied by the AMA's Council on Long Range Planning and Development for restructuring the AMA's membership to the Board for consideration at its meeting in March.

Council on Legislation

Optometry

Approved support of the Florida Society of Ophthalmology in its efforts to defeat U.S. Congressional proposals to allow reimbursement for aphakic care by Optometrists under Medicare.

FMA Auxiliary

Authorized appointment of an Auxiliary representative in each Congressional District to work with the National Key Contact Physician and County Medical Societies in carrying out the FMA's national legislative objectives.

Key Contact Physician Manual

Approved the development and distribution of a legislative manual to FMA national and state legislative key contact physicians.

Legislative Proposals

Adopted Association policy regarding proposed legislation to be addressed by the 1980 Legislature, however, deferred designation of FMA priorities pending a final review of 1980 legislative issues for the 1980 Session at the March Board meeting.

Prescribing and Use of Drugs — Went on record as supporting legislation prohibiting the use of drugs or surgery by practitioners other than M.D.'s, D.O.'s, Dentists, Veterinarians, and Podiatrists.

Controlled Substances — Approved a position of support for legislation to repeal the law prohibiting sampling of controlled substances to physicians.

Class II Drugs — Endorsed the need for more effective control of the abuse of Class II drugs including revkew of all appropriate mechanisms to accomplish this and if necessary, legislation requiring the use of a triplicate prescription form for prescribing Class II narcotics.

Lay Midwifery — Expressed support for legislation abolishing licensure of lay midwives (not certified nurse midwives) in Florida.

Council on Specialty Medicine

Physicians Practicing as P.A.'s

Expressed opposition to physicians not licensed in Florida working as P.A.'s within the State and expressed support for a revision to the Medical Practice Act to assure that the P.A. section is not used as a subterfuge for circumventing medical licensure in Florida and further recommended that the physician-P.A. ratio be addressed.

Infant Screening Program

Adopted a position concerning the recently promulgated rules and regulations for Florida's Infant Screening Program:

> The FMA supports the concept of neonatal screening for metabolic diseases. However, it does not support the implementation of the rules and regulations as promulgated by the Department of HRS based on the absence of input by all interested and involved health professionals; and suggests that the Department of HRS delay implementation until adequate input is obtained; and further
>
> Recommends that the Department of HRS Infant Screening Advisory Council be expanded to include representatives from the following specialty groups:
>
> Florida Society of Pathologists
> Florida Academy of Family Physicians
> Florida Endocrine Society
> Florida Obstetric & Gynecologic Society

X-Ray Certification

Authorized the Council on Specialty Medicine to continue its efforts in working with the Department of HRS to have the Home Study Guide for limited X-Ray certification amended to cover only basic safety aspects.

Legislation passed during the 1978 Session requiring certification of individuals who operate x-ray equipment. The Home Study Guide entitled "Fundamentals of X-Ray Technician Training" which has been developed for use in the certification process as well as the sample test questions, in the opinion of the Council, go far beyond legislative intent.

Council on Medical Services

Advanced Registered Nurse Practitioners

Approved the recommendation that the FMA request the State Board of Medical Examiners to review the list of Advanced Registered Nurse Practitioners' services proposed for Medicaid reimbursement for the purpose of determining if any of these procedures are the practice of medicine and not authorized by the Nurse Practitioners Act.

Florida Health Care Council

Approved distribution with the next issue of the FMA Briefs and educational brochure on Florida's Generic Drug Law developed by the Florida Health Care Information Council.

Committee on P.M.U.R.

P.M.U.R. Procedures

Received a report regarding the conduct and procedures of the peer review program and the efforts of the Committee to bring about improvements in response to concerns expressed by a number of county medical societies that the program was not functioning as it should.

Requested that the Committee solicit further comments from county medical societies prior to submitting a final report and recommendations regarding the peer review procedures to the Board at its meeting in March.

P.M.U.R. Workshop

Authorized a workshop for members of county medical society peer review committees during the 1980 Annual Meeting. It was noted that Dr. Mutter, Chairman of the State P.M.U.R. Committee, would be making a brief presentation on the P.M.U.R. program at the meeting of the FMA Committee on County Medical Societies on Sunday, January 27th, in conjunction with the FMA Leadership Conference. At the request of the Board of Governors, County Medical Society officers have been invited to participate in this meeting.

P.M.U.R. Journal Articles	Authorize a series of articles on peer review to be published monthly in the FMA Journal.	
FLAMPAC	Approved the appointment of the following physicians to the Board of Directors of FLAMPAC:	William W. Thompson, M.D. Robert E. Windom, M.D. John M. Hamilton, M.D. Reginald J. Stambaugh, M.D. Francis C. Coleman, M.D. Louis C. Murray, M.D. Carlos G. Llanes, M.D. Juan Sven Aage Wester, M.D. Mrs. B. D. Epstein



Dean's Page

Time for Renewal

E. M. Papper, M.D.

The advent of a new year for many of us is a time for optimism and renewal. However, it is very difficult in a school of medicine, or probably any other major activity to know with certainty what that might mean to us. One need simply examine any newspaper daily and one could be overwhelmed with the magnitude of the problems that the world faces.

A school of medicine is, after all, a part of the support system of a society that is committed to the preservation of health and to the treatment of disease for its people. What has all this to do with the mood that seems to be one of discouragement with events in the Near East, Middle East, the energy problem, and the negative effects of inflation?

There are always some, fortunately, who feel that when things look pessimistic and difficult around them there must be opportunities available to those who have the vision to see the opportunities as well as the energy and the will to act upon them. The legends of Bernard Baruch and Joseph P. Kennedy are examples of these insights.

An example in the health field is the fact that many people in our state, our country and in the western world, enjoy a degree of health that has been unprecedented in the past. Coupled with that happy fact about which nothing much is done except to appreciate it, is the increasing sensitivity and awareness that many of us are feeling about the walls of medical ignorance that surround and prevent our understanding the basic mechanisms of disease, thereby becomes at best empiric under these circumstances.

It seems to me that one of the opportunities for a school of medicine and for an academic health center at this time of year is to renew its commitment to chipping away at these walls of ignorance to make more possible the good life we wish. With the inevitable reduction of ignorance which can only come with hard work in research and its application to patient care as rapidly as possible, the good health standards that we have already achieved will certainly become better. I think there is ample room for optimism in that human problems, whether they be in the life sciences, in health care or in the larger world which we serve, should be amenable one day to human intelligence and to the improvement that needs to be achieved.

One has to feel encouraged by the common sense of the people who increasingly show signs of using the knowledge that already exists in their life habits and to being supportive of the need to acquire new knowledge where ignorance is so vast. If we knew more about disease mechanisms, we could speed up, ever so rapidly, more national management of many of our ills.

One of the opportunities we must seize with the advent of a new year and a new decade is a renewed commitment to reducing our collective ignorance. We must also provide a more enthusiastic support of life habits that are designed to take advantage of what we already know. The gain of more knowledge should make it possible to enter more firmly into the area of prevention of disease and to the reversal of those disease risks.

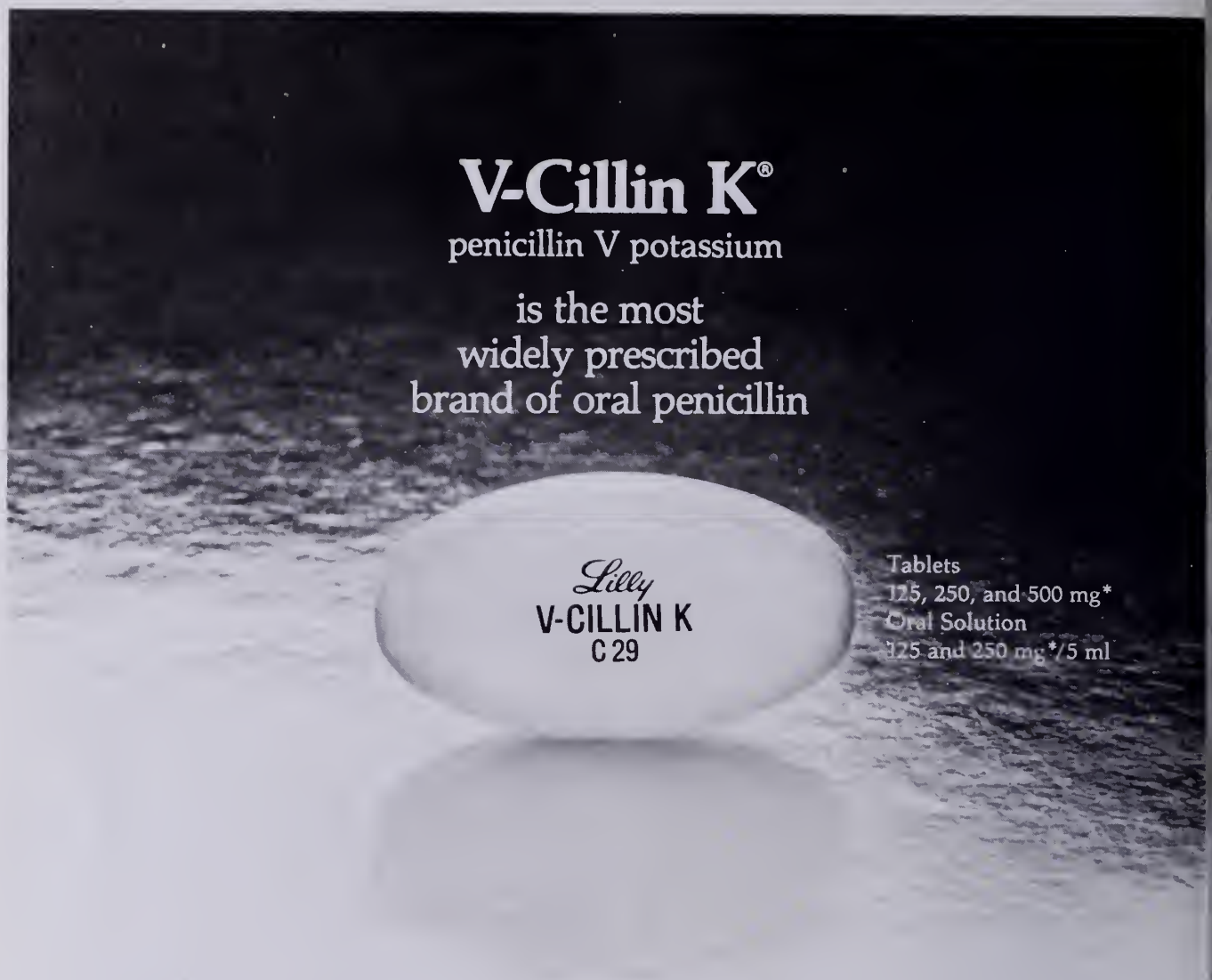
I believe these are opportunities that should be seized by those willing to do so and those who have the intelligence to be the prime movers and leaders in this direction.

It is necessary for all of us in our profession, whether in the delivery aspect, the preventive aspect, or in the educational or research aspects to support each others needs for the common welfare of those we serve.

Dr. Papper is Vice President for Medical Affairs and Dean, University of Miami School of Medicine, Miami.

● Dr. Papper, University of Miami School of Medicine, P. O. Box 016960, Miami 33101.

The opinions stated on this page are those of the individual Deans and do not necessarily represent the policy of the FMA.



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Precautions: Use with caution in individuals with histories of significant allergies and/or asthma. Do not rely on oral administration in patients with severe illness, nausea, vomiting, gastric dilatation, cardiospasm, or intestinal hypermotility. Occasional patients will not absorb therapeutic amounts given orally. In streptococcal infections, treat until the organism is eliminated (minimum of ten days). With prolonged use, nonsusceptible organisms, including fungi, may overgrow; treat superinfection appropriately.

Adverse Reactions: Hypersensitivity, including fatal anaphylaxis. Nausea, vomiting, epigastric distress, diarrhea, and black, hairy tongue. Skin eruptions, urticaria, reactions resembling serum sickness (including chills, edema, arthralgia, prostration), laryngeal edema, fever, and eosinophilia. Infrequent hemolytic anemia, leukopenia, thrombocytopenia, neuropathy, and nephropathy, usually with high doses of parenteral penicillin. (102175)

***Equivalent to penicillin V.**

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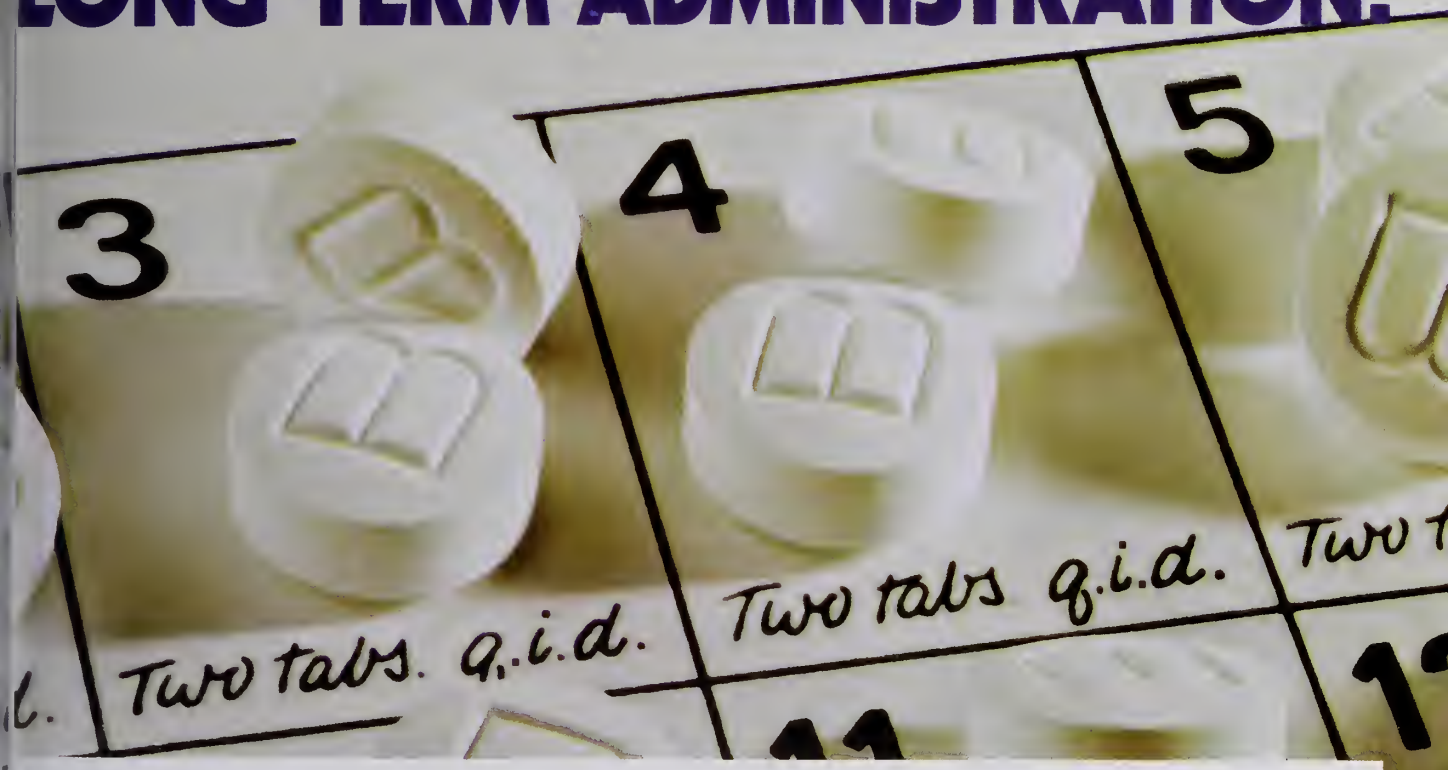
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ZERO-ORDER dc/dt=K™

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Dosage and Administration: Average initial dose is 100 mg to 300 mg q12h depending on the age and weight of the patient and the severity of the disease. See package insert for full prescribing information.

See following page for a brief summary of prescribing information.

KEY PHARMACEUTICALS, INC.
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THEO-DUR™

Enduring Action Anhydrous Theophylline

Sustained Action Tablets

Description: THEO-DUR Sustained Action Tablets contain anhydrous theophylline, with no color additives.

Actions: The pharmacologic actions of theophylline are as a bronchodilator, pulmonary vasodilator and smooth muscle relaxant since the drug directly relaxes the smooth muscle of the bronchial airways and pulmonary blood vessels. Theophylline also possesses other actions typical of the xanthine derivatives: coronary vasodilator, diuretic, cardiac stimulant, cerebral stimulant and skeletal muscle stimulant. The actions of theophylline may be mediated through inhibition of phosphodiesterase and a resultant increase in intracellular cyclic AMP which could mediate smooth muscle relaxation.

Indications: Symptomatic relief and/or prevention of asthma and reversible bronchospasm associated with chronic bronchitis and emphysema.

Contraindications: THEO-DUR is contraindicated in individuals who have shown hypersensitivity to any of its components or xanthine derivatives.

Warnings: Excessive theophylline doses may be associated with toxicity; serum theophylline levels should be monitored to assure maximum benefit with minimum risk. Incidence of toxicity increases at serum levels greater than 20 mcg/ml. High blood levels of theophylline resulting from conventional doses are correlated with clinical manifestations of toxicity in: patients with lowered body plasma clearances, patients with liver dysfunction or chronic obstructive lung disease, and patients who are older than 55 years of age, particularly males. There are often no early signs of less serious theophylline toxicity such as nausea and restlessness, which may appear in up to 50% of patients prior to onset of convulsions. Ventricular arrhythmias or seizures may be the first signs of toxicity.

Many patients who have higher theophylline serum levels exhibit a tachycardia. Theophylline products may worsen pre-existing arrhythmias.

Usage in Pregnancy: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development, but neither have adverse effects on fetal development been established. This is, unfortunately, true for most anti-asthmatic medications. Therefore, use of theophylline in pregnant women should be balanced against the risk of uncontrolled asthma.

Precautions: THEO-DUR TABLETS SHOULD NOT BE CHEWED OR CRUSHED. Theophyllines should not be administered concurrently with other xanthine medications. It should be used with caution in patients with severe cardiac disease, severe hypoxemia, hypertension, hyperthyroidism, acute myocardial injury, cor pulmonale, congestive heart failure, liver disease and in the elderly, particularly males, and in neonates. Great caution should be used in giving theophylline to patients in congestive heart failure since these patients show markedly prolonged theophylline blood level curves. Use theophylline cautiously in patients with history of peptic ulcer. Theophylline may occasionally act as a local irritant to G.I. tract although gastrointestinal symptoms are more commonly central and associated with high serum concentrations above 20 mcg/ml.

Adverse Reactions: The most consistent adverse reactions are usually due to overdose and are:

Gastrointestinal: Nausea, vomiting, epigastric pain, hematemesis, diarrhea.

Central Nervous System: Headaches, irritability, restlessness, insomnia, reflex hyperexcitability, muscle twitching, clonic and tonic generalized convulsions.

Cardiovascular: Palpitation, tachycardia, extrasystoles, flushing, hypotension, circulatory failure, life threatening ventricular arrhythmias.

Respiratory: Tachypnea.

Renal: Albuminuria, increased excretion of renal tubular cells and red blood cells; potentiation of diuresis.

Others: Hyperglycemia and inappropriate ADH syndrome.

How Supplied: THEO-DUR 100 mg, 200 mg and 300 mg Sustained Action Tablets are available in bottles of 100, 1000, and 5000, and in unit dose packages of 100 (20 x 5's).

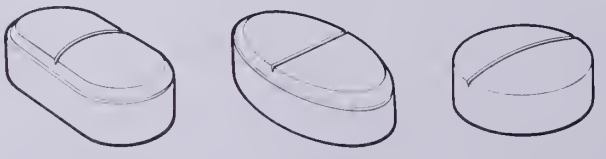
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Nature just doesn't make a perfect food.

No one food supplies all the nutrients children need.

But milk supplies more essential nutrients per calorie than most other foods.

A child between the ages of six months and six years, for example, can get at least three-fourths of his daily dietary allowance for calcium, riboflavin, vitamins D and B_{12}, phosphorous, and protein from just three glasses of milk. And milk is also a good source of vitamins A and B_6, as well as thiamin and niacin (please see chart).

That's why the U.S.D.A., acting on the recommendation of the National Research Council—National Academy of Sciences, has established these guidelines for milk consumption:

Children up to 6 years
Two to three 8 oz. glasses per day.

Children 6 to 12 years
Three or more 8 oz. glasses per day.

For a free copy of the Dairy Council Digest issue titled, "Composition and Nutrient Value of Dairy Foods," contact your local Dairy Council or write the National Dairy Council, 6300 North River Road, Rosemont, Illinois 60018.

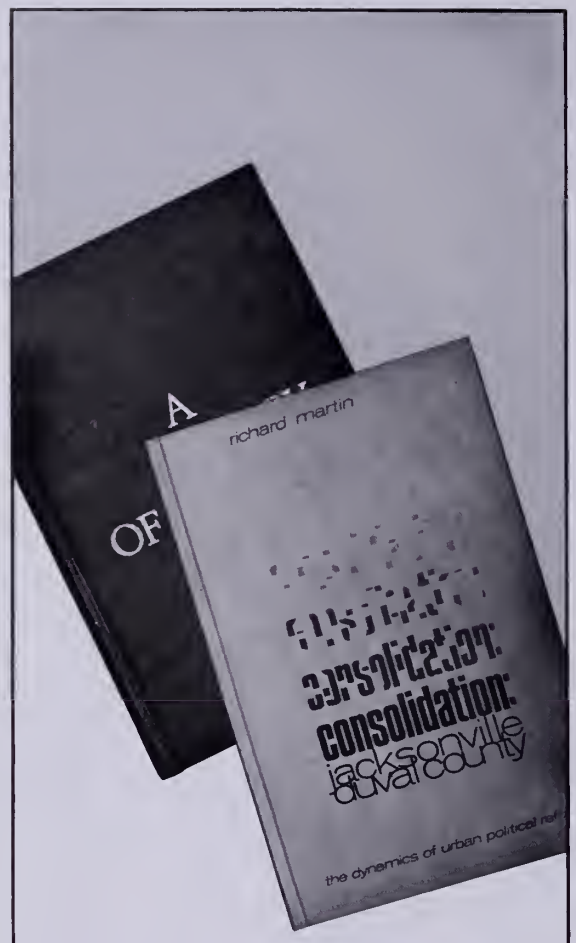
Per cent of Recommended Daily Allowance contributed by three 8 oz. glasses of fortified milk.

	6 mos.—1 yr.	1 yr.—3 yrs.	3 yrs.—6 yrs.
Calcium	100%	100%	100%
Riboflavin	100	100	100
Vitamin B_{12}	100	100	100
Protein	100	100	80
Phosphorus	100	85	85
Vitamin B_6	76	51	34
Vitamin D	75	75	75
Niacin*	71	63	47
Thiamin	56	40	31
Vitamin A	46	46	37

*maximum niacin equivalents based on: 60 mg tryptophan=1 mg niacin

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Brief Summary

INDICATIONS: For the prevention and treatment of nocturnal recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis, and static foot deformities.

CONTRAINDICATIONS: Because of the quinine content, Quinamm is contraindicated in women of childbearing potential, in pregnancy, in patients with known quinine sensitivity, and in patients with glucose-6-phosphate dehydrogenase deficiency. Hemolysis (with the potential for hemolytic anemia) has been associated with a G-6-PD deficiency in patients taking quinine.

PRECAUTIONS: Thrombocytopenic purpura may follow the administration of quinine in highly sensitive patients. Recovery will follow withdrawal of the medication.
Cinchona alkaloids, including quinine, have the potential to depress the hepatic enzyme system that synthesizes the vitamin K-dependent factors. The resulting hypoprothrombinemic effect may enhance the action of warfarin and other oral anticoagulants.

ADVERSE REACTIONS: Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. If ringing in the ears, deafness, skin rash, or visual disturbances occur, the drug should be discontinued.

DOSAGE AND ADMINISTRATION:
1 tablet upon retiring. When necessary, 1 additional tablet may be taken following the evening meal.

Product Information as of September, 1977

U.S. Patent 2,985,558

Merrell

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Cayey, Puerto Rico 00633

Direct Medical Inquiries to:
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Cincinnati, Ohio 45215, U.S.A.

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Quinamm™

each tablet contains quinine sulfate 260 mg., aminophylline 195 mg.

specific therapy for painful night leg cramps

Nocturnal recumbency leg muscle cramping is frequently an unwelcome bedfellow for many patients—especially those with arthritis, diabetes or peripheral vascular disease... consider Quinamm... simple, convenient dosage—usually just one tablet at bedtime... can provide restful, welcome sleep without night leg cramps.

See opposite page for prescribing information.

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It's for all kinds of hypertensives

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- *Catapres can be useful even in these patients with:*

Congestive heart failure	Allergic rhinitis
Ventricular hypertrophy	Hepatic disease
Hyperglycemia	Hyperuricemia
Diabetes mellitus	Gouty arthritis
Bronchial asthma	Sulfonamide hypersensitivity

- Like any antihypertensive, use with caution in severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

work/play—normal hemodynamic responses to exercise maintained.

love—low incidence of impotence and/or loss of libido: 2.8% in 1,923 patients studied.[1]

cardiac output—tends to return to control values during long-term therapy.

blood flow—preserved in kidney.

No Single Advantage Determines Drug Choice.

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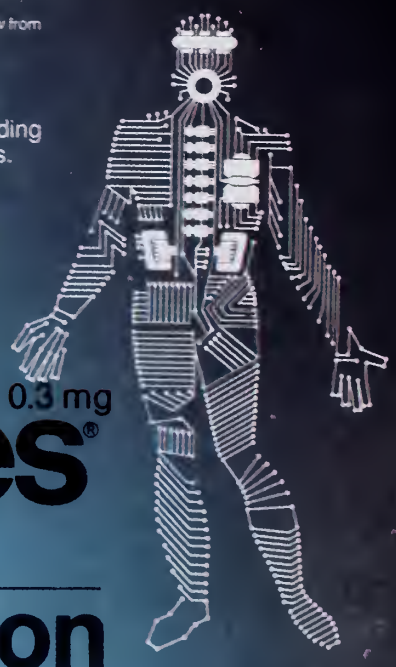
The drug's effectiveness in a given patient, its side effects, warnings, precautions, tolerance, etc. A rational therapeutic choice depends on a careful assessment of all such factors.

*Central alpha-adrenergic stimulation decreases sympathetic outflow from the brain, as shown in animal studies.

1. Data on file at Boehringer Ingelheim Ltd.

Please see last page for brief summary, including warnings, precautions, and adverse reactions.

Now available in new 0.3 mg tablets

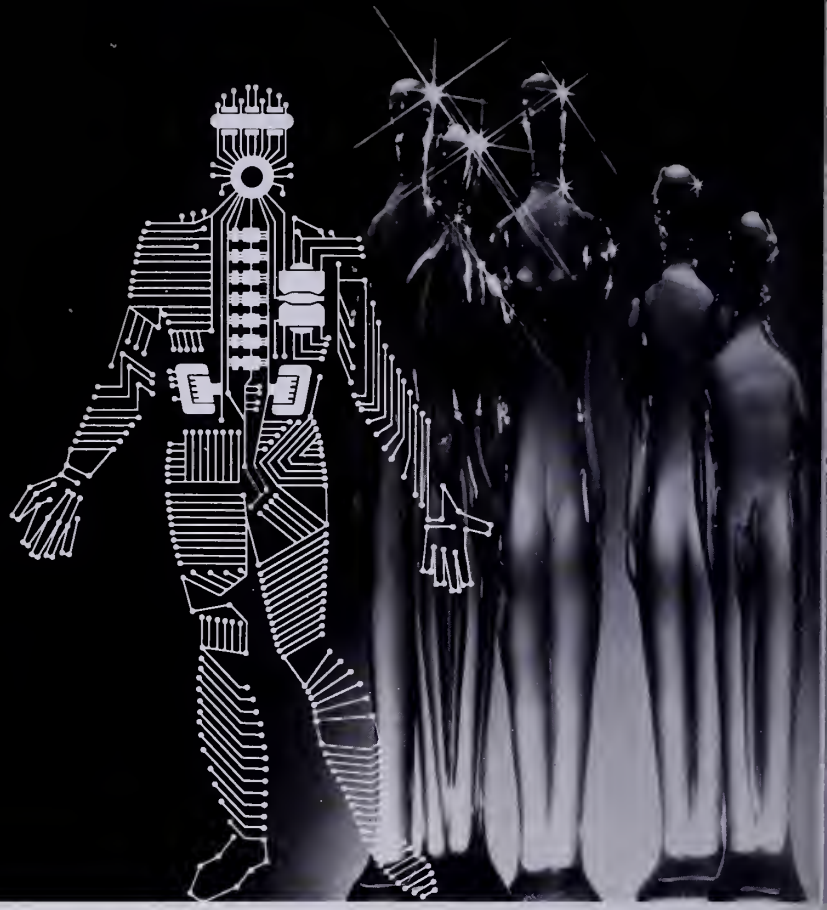


Tablets of 0.1, 0.2, 0.3 mg

Catapres®
(clonidine HCl)
Hypertension

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Catapres®

(clonidine HCl)

Hypertension

- No contraindications.
- Effective in all degrees of hypertension. It is mild to moderate in potency.
- Low incidence of depression, impotence, orthostatic hypotension—no fatal hepatotoxicity.
- Preserves kidney blood flow.

Most common side effects are dry mouth, drowsiness, and sedation which generally tend to diminish with time.

The usual starting dose of Catapres is 0.1 mg at breal fast and 0.1 mg at bedtime. Some patients may benef from a starting dose of 0.1 mg at bedtime.

Usual daily dose range—0.2—0.8 mg

Maximum daily dose—2.4 mg
Doses as high as this have rarely been employed.

For optimal results, the dose of Catapres must be adjusted according to the patient's individual blood pressure response.

Catapres®
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Indication: The drug is indicated in the treatment of hypertension. As an antihypertensive drug, Catapres (clonidine hydrochloride) is mild to moderate in potency. It may be employed in a general treatment program with a diuretic and/or other antihypertensive agents as needed for proper patient response.

Warnings: Tolerance may develop in some patients necessitating a reevaluation of therapy.
Usage in Pregnancy: In view of embryotoxic findings in animals, and since information on possible adverse effects in pregnant women is limited to uncontrolled clinical data, the drug is not recommended in women who are or may become pregnant unless the potential benefits outweigh the potential risk to mother and fetus.
Usage in Children: No clinical experience is available with the use of Catapres (clonidine hydrochloride) in children.

Precautions: When discontinuing Catapres (clonidine hydrochloride), reduce the dose gradually over 2 to 4 days to avoid a possible rapid rise in blood pressure and associated subjective symptoms such as nervousness, agitation, and headache. Patients should be instructed not to discontinue therapy without consulting their physician. Rare instances of hypertensive encephalopathy and death have been recorded after cessation of clonidine hydrochloride therapy. A causal relationship has not been established in these cases. It has been demonstrated that an excessive rise in blood pressure, should it occur, can be reversed by resumption of clonidine hydrochloride therapy or by intravenous phentolamine. Patients who engage in potentially hazardous activities, such as operating machinery or driving, should be advised of the sedative effect. This drug may enhance the CNS-depressive effects of alcohol, barbiturates and other sedatives. Like any other agent lowering blood pressure, clonidine hydrochloride should be used with caution in patients with severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

As an integral part of their overall long-term care, patients treated with Catapres (clonidine hydrochloride) should receive periodic eye examinations. While, except for some dryness of the eyes, no drug-related abnormal ophthalmologic findings have been recorded with Catapres (clonidine hydrochloride), in several studies the drug produced a dose-dependent increase in the incidence and severity of spontaneously occurring retinal degeneration in albino rats treated for 6 mon longer.

Adverse Reactions: The most common reactions are dry mouth, drowsines sedation. Constipation, dizziness, headache, and fatigue have been rep Generally these effects tend to diminish with continued therapy. The foll reactions have been associated with the drug, some of them rarely. (In instances an exact causal relationship has not been established.) These in Anorexia, malaise, nausea, vomiting, parotid pain, mild transient abnormali liver function tests; one report of possible drug-induced hepatitis without i and hyperbilirubinemia in a patient receiving clonidine hydrochloride, thalidone and papaverine hydrochloride. Weight gain, transient elevation of glucose, or serum creatine phosphokinase: congestive heart failure, Rayr phenomenon; vivid dreams or nightmares, insomnia, other behavioral cha nervousness, restlessness, anxiety and mental depression. Also rash gioneurotic edema, hives, urticaria, thinning of the hair, pruritus not asso with a rash, impotence, urinary retention, increased sensitivity to alcohol, dr itching or burning of the eyes, dryness of the nasal mucosa, pallor, gynecor weakly positive Coombs' test, asymptomatic electrocardiographic abnorm manifested as Wenckebach period or ventricular trigeminy.

Overdosage: Profound hypotension, weakness, somnolence, diminished sent reflexes and vomiting followed the accidental ingestion of Catapres (clo hydrochloride) by several children from 19 months to 5 years of age. C lavage and administration of an analeptic and vasopressor led to comple covery within 24 hours. Tolazoline in intravenous doses of 10 mg at 30-r intervals usually abolishes all effects of Catapres, (clonidine hydrochloride dosage.

How Supplied: Catapres, brand of clonidine hydrochloride, is available as C (tan) and 0.2 mg (orange) oval, single-scored tablets in bottles of 100 and 100 available as 0.3 mg (peach) oval, single-scored tablets in bottles of 100.

For complete details, please see full prescribing information.
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Professional Liability Legal Update

Physician Misconduct—New Trial

A Maryland appellate court has ruled that a physician's misconduct in allegedly intimidating two expert witnesses who testified against him in a malpractice suit entitled the claimant to a new trial after verdict had been rendered in favor of the physician in the initial action. It was demonstrated on appeal that during the trial, defendant called upon other physicians to contact the two experts who were scheduled to testify against defendant at trial. Both expert witnesses were allegedly informed that their testimony would be transcribed and disseminated to members of their medical societies. In addition, it was allegedly suggested to one expert that it might not be a particularly good thing for him to testify against defendant in the malpractice trial because of his impending appearance before the American Board of Neurological Surgeons for the oral portions of his certification examinations. The plaintiff contended that the trial judge erred in instructing the jury that evidence of the defendant's tampering with the expert witnesses was admissible only for the purpose of raising an inference that the testimony of the witness would be unfavorable to the defendant, rather than as substantive evidence to support the plaintiff's claim. From a jury verdict in favor of defendant, plaintiff appealed.

In reversing the trial court's verdict, the appellate court stated that it considered the physician's conduct to be outrageous. In both cases, the physicians who contacted the expert witnesses were their former teachers who were held in extremely high regard by the testifying physicians. Both experts testified that the conversations with their former mentors significantly affected their testimony. Therefore, the appellate court ruled that the evidence regarding witness tampering by the defendant should have been introduced on the issue of negligence as direct evidence of the physician's concious realization of the weakness of his case. *Meyer v. McDonnell 392 A.2d 1129 (Md. App. 1978)*

Scope of Professional Liability Insurance Coverage

A physician was sued by the husband of one of his patients who alleged that during the course of his treatment the doctor had intentionally and negligently engaged in a course of conduct with plaintiff's wife which was intended to, and did, have the affect of alienating the affections of the wife and causing her to divorce the plaintiff. Shortly after receiving service of the complaint, the physician, through his attorney, tendered it to his professional liability insurance company. The insurer denied any obligation to defend against the complaint on the ground that the acts complained of did not constitute "professional services" and that it was contrary to public policy to insure against the activities alleged. Subsequently, the physician voluntarily made a settlement with the complaining husband and filed an action against the insurance company contending that the insurer was obligated by the terms of his insurance policy to defend against an action for alienation of affections and that, therefore, the insurer was liable for the costs of settling the action filed against the physician by a third party. The trial court entered summary judgement in favor of the insurer and the physician appealed. On appeal, the appellate court upheld the lower court's ruling, agreeing that public policy prevented an insurer from providing coverage against such a cause of action. *Eberdt v. St. Paul Fire and Marine Ins. Co., 585 P.2d 711 (Ore. App. 1978).*

Prepared and submitted by John E. Thrasher, J.D., Vice President and Legal Counsel and Anthony J. McNicholas, III, J.D., Associate Legal Counsel, Professional Insurance Management Co. (PIMCO), Jacksonville, Florida.

Acknowledgements

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The editor wishes to acknowledge, gratefully, the hours devoted by Mrs. Constance Garner and her staff, in the organization, compiling, and the innumerable telephone calls, and all of the other tedium which is required in compiling an issue such as this, especially with an inexperienced editor. Mrs. Garner is Supervisor of the secretarial staff in the Department of Pathology, Holmes Regional Medical Center, Melbourne, Florida.

Laudie E. McHenry, M.D.

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Special Issue On Pathology
Guest Editors

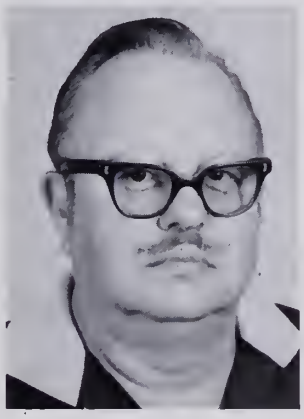
Laudie E. McHenry, M.D. and Pablo Enriquez, M.D.

Introduction

This Special Issue of the Journal of the Florida Medical Association is sponsored and subsidized by the Florida Society of Pathologists. Although the Editors will immodestly accept some credit for such success as this issue may have, the major portion of the credit for any success of this issue must be given to the many contributors of the scientific articles. Most of these authors are Florida physicians, many renowned nationally in their own right, many others being the friendly pathologists you encounter on a day-to-day basis in the community hospitals in Florida. Only three of the articles are contributed by out-of-state pathologists and scientists, and these were especially invited by the Editors. Among the out-of-state contributors, we have a contribution from one of the world's outstanding clinical enzymologists, from one of the major scientists developing studies in the field of drug-monitoring, and from an outstanding surgical pathologist from Minnesota.

In selecting the topics covered in this issue, and in the writing, we have tried to make these articles significantly informative, not only to pathologists, but to other specialties and, certainly, to the family physician. The Editors believe that we have succeeded in this purpose. In addition, one article ("As Others See Us"), contains multiple viewpoints of the pathologist as viewed from other specialties. We felt that this might be good, or at least balancing, for egos.

We can find articles, and we believe, important contributions, in the fields of socioeconomic review, peer review programs, hematology, forensic medicine, pediat-



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rics, varied clinical pathology subjects, including drug-monitoring updates, clinical enzymology, and thyroid studies, blood banking, and, last but not least, surgical pathology. All of these sections have not only updating articles, but articles which are on definitive topics; some of which may be worthy of national attention. It is interesting, indeed, that the largest section of the issue deals with pediatrics.

In reviewing these various articles, the Editors have selected several which will provide some help in our own laboratories. We hope that the pathologists throughout the state will glean also some useful information, and that Florida practitioners, in all specialty areas, can gain some useful information from the articles in this issue.

The Editors have taken the liberty of making acknowledgements at irregular intervals through this issue. It is impossible to specify individuals responsible for the success of such an issue without overlooking some person who played a key role. Therefore, the Editors wish to state their grateful appreciation to all persons who had any assignment or contribution, large or small, in the creation of this issue.

About the Cover

The cover depicts a clinical pathologist, with the background showing a new marvel of the age of automatons. Does the expression depicted on the pathologist's face give a hint of the ecstacy which he feels as the result of the greater precision, combined with the greater rapidity with which he can furnish his services to the patient; or, is the expression one of frustration, such as might be experienced when the electronic marvel has been rendered inoperable by an uncontrollable fact of life, such as an unexpected voltage surge due to a Florida thunderstorm?

About the Artist

The cover of this issue is a work drawn by Dr. Leon Termin, pathologist at Palmetto General Hospital in Hialeah, Florida. In his youth, Dr. Termin trained for a career in art by attending the Pratt Institute, the Academy of the Brooklyn Art Museum and the School of Industrial Arts. Before becoming a physician he worked in advertising as a commercial illustrator. Now that he is Director of Pathology at Palmetto General Hospital, he has only occasionally had the opportunity to channel his talents into medical illustration. His most recent artwork can be found in two textbooks, Pillsbury's Dermatology and Ackerman's Histologic Diagnosis of Inflammatory Skin Diseases.



Dr. Termin

Editor's End-Note

Just as our issue was finalized and handed to the JFMA editorial office, a major crisis arose. Because of escalating printing costs, combined with a limited budget, it became quite clear that the full issue could **not** be printed. As requested by the guest editors, thirty-nine articles had been submitted. These covered the topics specifically designated by the editors, and all of the articles were well written, many considered outstanding. The editors took the dilemma to many of our colleagues, including the Editorial Committee and the officers of the FSP. The inescapable conclusion was that the issue had to be cut, with deletion of many fine articles. This heart rendering task was one of the most difficult of our professional careers, but cut we did, and the ensuing text is the final result. To those whose articles were deleted, we humbly apologize, not for the cutting so much as the many hours of toil that we had requested of you in preparing the article. (Reflecting on this situation, the title of this section, "Editor's End-Note," is probably prophetic).

In addition to the deletion of articles, we have economized by not listing the references of the published articles. To those interested, the references are available on request to the guest editors.

Also, because we feel strongly that the deleted articles are worthy of your attention, we have listed and summarized these articles below. Any of these will be forwarded to you on requests directed to the guest editors.

— **College of American Pathologists Inspection and Accreditation Program**
by Anthony R. Clerch, M.D.

This is a report of the involvement of Florida pathologists and laboratories in the Inspection and Accreditation Program of the College of American Pathologists, probably the leading peer review program now current in organized medicine.

— **The Making of a Pathologist**
by Azorides Morales, M.D.

This article, by the Chairman of a University Department of Pathology, reviews the diversity of the pathologist's work and the general principles of training programs devised to accomplish appropriate preparation for the above.

— **On Monitoring Heparin Therapy**
by John B. Miale, M.D.

The author discusses the current techniques used in monitoring heparin therapy and provides his own expertise and recommendations on this important topic. The reader who utilizes heparin therapy should request a copy of this article.

— **Lymphomas and Leukemias — Exceptions**
by Pablo Enriquez, M.D.

Lymphomas and Leukemias are easily separable on most occasions. Exceptions to the above rule do occur and this article deals with these exceptions.

— **The Pediatric Autopsy**
by William H. Donnelly, M.D.

This article is highly recommended to those readers who perform or are associated with the performance of pediatric autopsies. The author describes the unique qualities of the pediatric autopsy and goes into some detail on techniques involved in all aspects of the pediatric autopsy.

— **Automation in Florida Blood Banking**
by Glenn S. Hooper, M.D. and
George M. Katibah, M.D.

Two Florida Blood Bankers tell of their experiences in the early automation of their Blood Banks.

— **Blood Banking in the year 2000**
by Paul J. Schmidt, M.D.

A prominent Florida Blood Bank Director looks ahead to the year 2000 and speculates on the changes that will have occurred by then.

— **Application of Homogeneous Enzyme Immunossay (EMIT) To Therapeutic Drug Monitoring**
by David S. Kabakoff, Ph.D., and Signe Gotcher

This is an outstanding and complete article dealing with the EMIT system in the field of Drug Monitoring. The immunologic aspects of drug monitoring are covered and the practical laboratory aspects of drug monitoring are covered in this article. If the reader's interest includes drug monitoring at the laboratory level, he should request this article.

— **Advances in Clinical Microbiology**
by Gerald L. Harris, M.D.

The author looks at the current microbiological laboratory, and discusses briefly, some of the current equipment now available and, as seen on the horizon.

— **Clinical Enzymology**
by John Griffiths, M.D.

The author is one of the world's outstanding clinical enzymologists and has prepared this article as a current updating of the clinical status of the following enzymes and isoenzymes: LDH, CK, ALP, ACP, GGT, Amylase. The reader whose interest encompasses the field of clinical enzymology should request this article.

— **Toxicology — an Essential and Practical Service in the Community Hospital**
by Judith E. Loebel, M.T., B.A.

The author, a clinical chemist, discusses the level of toxicology that should be practiced in the community hospital, both for emergency room, clinical, and forensic purposes. Instrumenation and techniques in the toxicologic laboratory are discussed.

— **The Autopsy — Current Assessment**
by Morton J. Robinson, M.D.

The article reviews the historical meaning of the autopsy, its present applicabilities, and its future.

—**Electron Microscopy—Practical Applications to Current Medical Practice**
by R.W. Alexander, M.D., Professor of Pathology, University of Florida Medical School.

This article is a comprehensive summary of the benefits that can be derived from Electron Microscopy by the surgical pathologist. This is an excellent summary of the current state of the art of Electron Microscopy.

Message From the President of the Florida Society of Pathologists

The Florida Society of Pathologists is proud to co-sponsor this issue of The Journal of the Florida Medical Association.

The role of the Pathologist as teacher is fundamental and the Florida Society of Pathologists has a significant commitment to post-graduate medical education. To facilitate the educational process we conduct a minimum of four major seminars and workshops throughout the state annually. In this manner Pathologists and their clinical colleagues may accumulate thirty or more Category A1 credits towards the Continuing Medical Education programs of their speciality society or the Physicians Recognition Award of the American Medical Association.

Whenever possible the editorial staff of this issue has instructed authors to provide material of direct value in patient care. Many of us have thus left our pet projects in the laboratory for another day. As you review this issue you will notice that it is oriented toward the more practical aspects of clinical medicine.

The issue would be incomplete without a word of appreciation to the Editor. This is, in a sense, a "command performance." As you may remember, Dr. Laudie McHenry served as collaborating Guest Editor of the Special Issue of The Journal of the Florida Medical Association in March, 1978 dedicated to Adverse Reactions to Plants in Florida. The national acclaim generated by that issue will be hard to match. It will remain on many of our library shelves as the definitive text in its field. Dr. McHenry is presently recuperating from major surgery but insisted throughout his illness that he honor his commitment to publication of this issue. We recognize the effort involved and are indebted to Laudie for his labor of love.

Dan Seckinger, M.D., President
Florida Society of Pathologists

A Brief Look at the Sociopolitical and Economic History of Pathology in the United States

Frank C. Coleman, M. D.

Pathology deals with the fundamental characteristics of disease. The word "pathology" has been in use for many years but until the last century it was applied to anatomic pathology only. Anatomic pathology deals with the structural changes of disease. More recently, clinical pathology has come into prominence. Clinical pathology deals with the functional changes of disease.

Performance of autopsies was the earliest procedure used in anatomic pathology. Among the first recorded autopsies in North America was one performed in 1535 on a sailor who had died during a voyage to Newfoundland. This sailor had clinical evidence of scurvy. The autopsy report was inconclusive. Medicolegal autopsies were also performed during the early years of United States history. Such an autopsy was performed in 1691 on the Governor of New York when he died shortly after assuming office. There was public concern because the Governor died shortly after approving the execution of a political rival. The autopsy yielded no evidence of foul play.

Dr. Benjamin Rush, Professor of the Institute of Medicine and the Practice of Medicine at the University of Pennsylvania, the first medical school established in the United States, incorporated the study of pathology in the courses given to his students during the early years of the 19th Century. Emphasis was placed on the structural changes in disease. Professors at other university medical centers such as Johns Hopkins and Harvard taught their students in essentially the same way.

In order to trace the evolution of clinical pathology, one must turn to the German-speaking countries. It was there that clinical laboratory disciplines were first studied in a systematic manner. Books authored in these countries which included sections on laboratory diagnosis were of two types. The first type was a composite with sections on history-taking and physical diagnosis as well as sections on laboratory medicine. One of the most famous of these composite texts was that of Herman Sahli. It was entitled *Clinical Methods of Investigation* and was published in 1894.

The other type was specialized and dealt only with laboratory diagnosis. One of the earliest was Carl Neubauer's *Treatise on the Urine* which appeared in 1854.

Most of the early practitioners of laboratory medicine believed that laboratory procedures were the prerogative of clinicians and should be utilized in the doctor's office or clinic as an adjunct to his practice.

This concept had been brought back to the United States by outstanding physicians such as Welch, Halstead, Osler, and Barker, following completion of their training in Germany or Austria.

In the final decades of the 19th Century, the bacteriologic techniques of Pasteur, Koch, and others were introduced into several of the medical schools of the



Dr. Coleman

The Author

FRANK C. COLEMAN, M.D.

Dr. Coleman, a resident of Tampa, has been engaged in the practice of Pathology since 1946. A charter member of the Board of Schools of Medical Technology of the American Society of Clinical Pathologists, he was a member of the Board of Governors of the College of American Pathologists from 1953 to 1958 and President of the College in 1960-61. He also served the College for eight years as Chairman of the Council on Government Relations and Liaison. For 12 years he was a Trustee, and in 1974-75 he was President of the American Board of Pathology. Dr. Coleman was an American Medical Association Delegate from Iowa from 1954 to 1960, and also has served as Chairman of the AMA Council on Legislative Activities. He was a founding member of the Board of Directors of the American Medical Political Action Committee (AMPAC) and served as Chairman for two years. In 1968-69, Dr. Coleman was President of the American Association of Blood Banks. On the state and local levels, Dr. Coleman serves at the present time as President of the Hillsborough County Medical Association, Chairman of the Florida Medical Association Council on Legislation, and Alternate Delegate to the AMA from the FMA.

United States. During the first decade of the 20th Century, clinical chemistry underwent a radical change. The techniques of Folin and Wu and of Van Slyke permitted analysis on small samples of material. Osler, for example, organized a special division of clinical chemistry at Johns Hopkins.

Most of these early laboratories were located in medical schools and were not developed in hospitals, nor were their services utilized in hospitals since most hospitals were not affiliated with medical schools. They were under the general supervision of clinicians who divided their time between laboratory medicine and clinical practice.

Dr. William Welch, Professor of Pathology at Johns Hopkins Medical School, stated the case for this combined arrangement when he said in 1896: "The subject matter for study in the clinical laboratory is primarily the patient and material derived from the patient . . . The clinical laboratory will concern itself more particularly with questions which bear directly upon the diagnosis and the treatment of disease."

In many medical schools and in most of the non-teaching hospitals, clinicians realized that complex laboratory procedures, if they were to be performed at all, must be delegated to specialists in laboratory medicine. This usually meant the pathologist. This trend was accentuated about sixty years ago when the hospital accreditation program of the American College of Surgeons included a requirement that all accredited hospitals have acceptable laboratory service.

From this time on, the number of pathologists active in Clinical Pathology increased rapidly. The trend accelerated with the founding of the American Society of Clinical Pathologists in 1923.

Those medical school centers that continued the old system, however, did so by bringing in Ph.D. scientists to direct their rapidly expanding clinical laboratories. These Ph.D. scientists worked under the general direction of the clinicians. Introduction of Ph.D. scientists into the clinical laboratory eventually led to conflicts between Clinical Pathologists and Ph.D. scientists and the establishment of non-medically directed commercial laboratories.

As the number of laboratories increased and there was a need to identify those that were performing acceptable work, the American Medical Association through its Council on Medical Education and Hospitals began to survey clinical laboratories. The surveys were confined to commercial laboratories doing clinical laboratory work for physicians. In 1926 the Council reported its first short list of approved clinical laboratories. By 1931 a total of 183 commercial laboratories were so recognized. That same year, however, the Council discontinued its listing of approved commercial laboratories. A new listing of pathologists and clinical pathologists was established the same year on the basis of their education, training and experience. Essentials for the listing of these physicians were published in 1932. Admission to the new approved list was open to all physician-practicing pathologists engaged in clinical pathologic work in accordance with the "Essentials" whether connected with a hospital or conducting an independent laboratory.

In 1931, 183 pathologists were listed. By October 1932 there were 538. Five of these were from Florida.

A physician holding himself out as a clinical pathologist was defined in these "Essentials" as follows: "One who is a graduate in medicine having specialized in clinical pathology, bacteriology, pathology, chemistry, or other allied subjects for at least three years subsequent to graduation, who is in good standing and has been duly licensed to practice medicine."

The "Essentials" also stated that "clinical pathology should be practiced on the same scientific and ethical basis, whether in a hospital or in a detached laboratory. The work represents the practice of medicine as in other specialties."

With the increasing utilization of technical personnel in clinical laboratories, there was a need for identifying competent medical technologists. This need led to the establishment by the American Society of Clinical Pathologists of the Registry of Medical Technologists in 1929. This Registry was responsible for evaluating both training programs and the competence of individual technologists. In 1949, however, the evaluation and accreditation of training programs was split off from the Registry and handed over to the newly established Board of Schools of Medical Technology of the American Society of Clinical Pathologists.

The American Board of Pathology was formed in 1936 and issued its first certificates in 1937. By 1940 the number of Diplomates had increased to 720 from the original 286. Certification was offered in Anatomic Pathology, Clinical Pathology, or both Anatomic and Clinical Pathology. Establishment of the Board of Pathology was a major step toward general professional recognition of Pathology as a medical specialty. Subspecialty certification soon followed with certification by the American Board of Pathology in Neuropathology in 1947, Medical Microbiology in 1949, Chemical Pathology in 1950, Hematology in 1952, Forensic Pathology in 1959, Blood Banking in 1973, Radioisotopic Pathology in 1974, and Dermatopathology in 1974.

As laboratories in hospitals increased in size, complexity and importance, and as they generated more income, hospital administrators took more interest in them. This increasing interest eventually led to major conflicts between hospitals and physicians over the

corporate practice of medicine.

The American Medical Association first recognized this problem in 1937 when its House of Delegates adopted the following report: "In principle . . . the interpretation of laboratory findings . . . constitute (s) the practice of medicine and should be confined to those who are licensed practitioners of laboratory medicine."

The following year the House of Delegates approved a recommendation of the Council on Medical Education and Hospitals that a study "be made of existing relationships between hospitals and physicians practicing therein, especially in the departments of anesthesiology, radiology, pathology and physical medicine."

In May 1939, the House of Delegates adopted a resolution which recommended that the practice of clinical pathology be recognized as a specialty of medicine.

During the following seven years, several strongly worded actions were taken by the House of Delegates with respect to physicians' services in Blue Cross/Blue Shield plans. These included:

"That the House emphatically reiterate that it disapproves the injecting of a third party into the personal relationship of the patient and the physician and that hospitals should not be permitted to practice medicine.

"That the practice of radiology, pathology and anesthesiology is the practice of medicine just as much as is the practice of surgery or medicine and that it is only a short step from including the first three in a medical service plan to including the whole field of medicine in such a plan.

"The medical profession must watch with care all proposed plans for medical service and endeavor to prevent the acceptance of any plan which includes medical service under the control of the hospital."

These policy statements clearly indicated the concern of physicians about the inclusion of medical services, especially those of radiologists, pathologists and anesthesiologists, in Blue Cross contracts rather than in Blue Shield contracts. Since Blue Cross plans were usually established prior to Blue Shield plans, services of hospital-based physicians were frequently included in Blue Cross contracts. As Blue Shield plans developed, hospitals vigorously resisted efforts to remove them from Blue Cross and transfer them to Blue Shield contracts.

The College of American Pathologists was founded in 1947. Much of the impetus for the establishment of this new organization came from the recognition by many pathologists of the need for a more aggressive role by pathologists in the socioeconomics of Pathology.

The organizational meeting of the College was held in late 1947 and Dr. Frank Hartman became its first president. An office for the College was established in Chicago with an executive staff and the College promptly initiated programs which included hospital-physician relations, a placement service and a laboratory standards program.

After the founding of the College with its interest in hospital-physician relations, the corporate practice of medicine controversy flared even more.

In 1947 the AMA House of Delegates adopted a resolution which stated:

"Resolved that the House of Delegates of the AMA is in complete agreement with the recommendations of the West Virginia State Medical Association in its opposition to the encroachment by hospitals and other organizations on the private practice of medicine.

"Resolved that all fees for medical services be set by and collected by or for physicians of medicine rendering this service, and that all policies and practices involving medical services be approved by the medical board or medical staff before being put into effect; and be it further

"Resolved that the Council on Medical Education and Hospitals recommend strongly that all hospitals conform to these resolutions; and be it further

"Resolved that the House of Delegates of the AMA go on record as strongly disapproving this practice of encroachment, and that notice of this action be sent to the American, Protestant and Catholic Hospital Associations and the Blue Cross organizations."

The next year the House approved the establishment of a special committee (the Hess Committee) "to study the various resolutions passed by the House of Delegates and to confer with other organizations to arrive at a solution." The Hess Committee submitted a report in 1949 which was accompanied by a Summary of a Study Relating to the Corporate Practice of Medicine in the United States that had been prepared by the Bureau of Legal Medicine and Legislation of the American Medical Association. This report stated: "The corporate practice of medicine is distinctly illegal in all of the states in the Union with some minor exceptions."

The report also quoted from the Principles of Medical Ethics of the American Medical Association, as follows: "It is unprofessional for a physician to dispose of his services under conditions that make it impossible to render adequate services to his patient or which interfere with reasonable competition among the physicians of a community."

"It is unprofessional for a physician to dispose of his professional attainments or services to any lay body, organization, group or individual, by whatever name called, or however organized, under terms or conditions which permit a direct profit from the fees, salary, or compensation received to accrue to the lay body or individual employing him."

The report then went on to state: "After considera-

tion of these Principles and of the Summary, it must be concluded that the over-all policy of the American Medical Association shall be that it is illegal, with the exceptions noted, and unethical for any lay corporation to practice medicine and to furnish medical services for a professional fee which shall be so divided as to produce profit for a lay employer, either individual or institutional (hospitals and medical schools)."

During this same period, significant changes were occurring in mechanisms for pathologist remuneration. At the end of World War II, most pathologists were on salary. After the war there was a technological explosion in the clinical laboratory and many new hospitals were being built under the Hill-Burton program.

Many hospital administrators and medical staffs wanted to improve the quality of laboratory services to patients in these institutions. Among these was Father Schwitalla, President of the Catholic Hospital Association. He, along with other hospital leaders, concluded that some changes in reimbursement mechanisms for hospital-based physicians might be effective in achieving this goal. The percentage contract for hospital-based physicians was one new mechanism that was recognized. The percentage contract was based on the economic principle of financial reward for increased productivity. There were many institutions, however, that aggressively resisted percentage contracts. As reimbursement mechanisms changed, the controversy over corporate practice accelerated in intensity.

In 1951 the American Medical Association published a "Guide for Conduct of Physicians in Relationship with Institutions." These guides spelled out the general principles to be followed by individual physicians, county medical societies and state medical associations as a basis for adjusting controversies between physicians and institutions. These principles included the following:

"(1) A physician should not dispose of his professional attainments or services to any hospital, corporation, or lay body, by whatever name called, or however organized, under terms or conditions which permit the sale of services of that physician by such agency for a fee.

"(2) When a hospital is not selling the services of a physician, the financial arrangement if any between the hospital and the physician properly may be placed on any mutually satisfactory basis. This refers to the remuneration of a physician for teaching or research or charitable services or the like.

"(3) The practice of anesthesiology, pathology, physical medicine and radiology are an integral part of the practice of medicine in the same category as the practice of surgery, internal medicine, or any other designated field of medicine."

In 1954 the Attorney General of Iowa rendered an opinion to the State Board of Medical Examiners which stated: "A corporation, whether or not organized or operated for profit, may not practice medicine and surgery in this state directly because of its inability as a legal entity to obtain a license, nor can it practice indirectly by hiring licensed members of that profession to do the actual professional work involved."

The Iowa Hospital Association and several member hospitals objected strenuously to this opinion. These objections resulted in a controversy between hospitals and physicians in Iowa. When the controversy could not be resolved by negotiation, the Iowa Hospital Association filed a lawsuit in District Court challenging the Attorney General's Opinion by asking for declaratory relief as to "whether or not the Plaintiff hospitals are engaged in the illegal corporate practice of medicine in purveying to patients in said hospitals medical services in the form of laboratory procedures and X-ray procedures for compensation."

After a trial of more than sixty days with testimony from a large number of witnesses, many of whom were from outside the State of Iowa, District Court Judge C. Edwin Moore handed down a landmark decision on December 7, 1955, which rejected the hospital association's arguments that radiology and pathology were not the practice of medicine and stated: "The Court does hereby refuse each and every one of the declarations sought by the Plaintiffs and said Petition is hereby dismissed."

The Iowa Hospital Association then took the controversy to the Iowa legislature in an effort to change the state law with respect to corporate practice. This effort failed.

A ripple effect from the Iowa decision was noted throughout the United States. Pathologists found it easier in many localities to develop satisfactory contractual relationships with hospitals. Unfortunately, many pathologists did not utilize the opportunity available to establish themselves as practitioners of medicine independent of hospital control.

In 1957 the first of a series of Medicare bills was introduced in the Congress of the United States. This bill would have placed pathology firmly under hospital control. Vigorous opposition to it and successor bills was launched by the American Medical Association and specialty societies, including the College of American Pathologists. It appeared for a time that these bills would be defeated. The picture changed drastically, however, with the assassination of President Kennedy in Dallas in November 1963. Medicare became a major issue in the presidential campaign of 1964. Following the overwhelming reelection victory of President Johnson, it was obvious that Medicare would become a reality.

As Medicare passed through the Congress, a head-to-head confrontation developed between the American

Hospital Association and the American Medical Association on how physicians' services would be covered. Congress finally decided that Medicare would be divided into two parts. Part A would be financed through increased Social Security taxes and would cover institutional services with reimbursement on a cost basis. Part B would cover physicians' services and would be financed by a combination of contributions by participants and general tax revenues with reimbursement on a reasonable charge basis. An aggressive effort was made by the hospitals to have the services of pathologists, radiologists and anesthesiologists included in Part A. This effort failed and pathologists' services were included under Part B.

After enactment of the Medicare law in 1965, and establishment of July 1, 1966 as the starting date, the Bureau of Health Insurance began work on regulations for the program. Several technical advisory committees were appointed to work with the staff of the Bureau of Health Insurance on them. One of these technical advisory committees worked on the "Conditions for Participation of Independent Laboratories." The initial draft of these regulations included radiologists' offices as well as independent clinical laboratories. Largely through the efforts of the American College of Radiology, radiologists' offices were dropped from coverage. An active debate raged for several months among pathologists as to whether the College of American Pathologists should attempt to have pathologist-directed independent laboratories excluded as well. The final decision was that pathologist-directed laboratories should be covered on the premise that these regulations would result in improvement in the quality of laboratory services. This decision was obviously a controversial one. Another Technical Advisory Committee on Specialists Services began work on the principles of reimbursement for provider costs and for services by hospital-based physicians. The initial draft of these principles as prepared by Bureau of Health Insurance staff divided the services of hospital-based physicians into those covered under Part B and those covered under Part A.

This decision was not consistent with the intent of Congress as expressed in committee reports accompanying the Medicare law. Nevertheless, the final regulations governing "Principles of Reimbursement for Provider Costs and for services by Hospital-Based Physicians" stated: "Under the law, benefit payments for the services of physicians (except for services of residents and interns under professionally-approved training programs) furnished to individual patients are under the supplementary medical insurance program. However, some of the services which hospital-based physicians perform are clearly not furnished to an individual patient. To the extent that the cost of such services is borne by the hospital, reimbursement will be made to the hospital under the hospital insurance program or, in certain cases, as a hospital cost under the supplementary medical insurance program."

The principle governing physicians' services under Part B in these regulations states: "A professional service rendered by a physician to a hospital patient that can be reimbursed only under the supplementary medical insurance program, as distinguished from his professional services which are of benefit to patients generally, means an identifiable service requiring performance by a physician in person, which contributes to the diagnosis of the condition of the patient . . . or contributes to the treatment of such patient.

"The component of the hospital-based physician's services for which reimbursement must be made under Part B . . . is only that part of his professional services with respect to which he is personally involved in the provision of services to individual patients as distinct from other professional services he may render in the hospital setting, such as teaching, research, performance of autopsies, committee work, quality control activities and administration. Compliance with this principle . . . normally will require determination with respect to each separate service or type of service rendered . . . and recordation of such charges on an item-by-item basis for each service rendered to a patient.

"Application of the item-by-item method may present special problems in the case of a particular hospital department . . . Where the physician participates personally in some procedures and not in others by virtue of quality control activities or because his professional concern is directed to the result in a given case, it may be difficult to ascertain the presence or absence of a specific quantum of professional activity in an individual case. . . . Administratively costly and impractical requirements could ensue in collecting the data needed for presentation of bills. . . . In order to facilitate administration, provide a better cost control, and to assure a practical basis for handling charges to individual patients, an optional method of recordation and billing may be elected upon agreement by the physician and the hospital in appropriate cases. Under this optional method, the component of the physician's services to patients would be determined for all Medicare patients through application of a uniform percentage to the total charges for such services in a particular department. . . . The percentage factor will be considered reasonable if it can be shown that it does not result from attributing as medical services to patients the costs of teaching, research, administration, and other services that are clearly reimbursable under the hospital insurance program.

"Election to use the optional method does not alter

the applicability of the principles as the basic criterion for distinguishing professional services chargeable under the supplementary medical insurance program from those to be included in the hospital's reimbursable costs."

Soon after these regulations were published, pathologists in several states changed their reimbursement mechanisms. A few negotiated lease contracts; others developed professional component billing arrangements using the optional method of reimbursement. Under professional component billing, the hospital provided laboratory personnel, supplies and equipment and was reimbursed on a cost basis under Part A. The pathologist submitted a professional charge for each laboratory procedure, which was reimbursed under Part B. In order for such an arrangement to be applicable to all patients, it was necessary for Blue Cross and Blue Shield contracts, as well as commercial insurance contracts, to recognize professional component billing. This recognition was slow in coming but did become a reality in several states. In Florida, professional component billing developed rather rapidly. By 1979, more than half of the pathologists in Florida were on professional component billing.

In 1966 the Justice Department of the federal government filed an antitrust action against the College of American Pathologists. The Justice Department complaint accused pathologists of monopolizing the clinical laboratory field and asked that the College be forced to alter its code of ethics, eliminate its guidelines for relationships with hospitals, withdraw its opposition to the solicitation of patients and specimens by mail, withdraw its opposition to advertising by clinical laboratories in medical publications, and withdraw its opposition to the use of detail men. This antitrust action never came to trial as it was settled by consent decree in June 1969 on advice of the attorneys of the College of American Pathologists. Most of the stipulations requested by the Justice Department were agreed to in this consent decree.

As part of its efforts to defend itself in this antitrust action, the College of American Pathologists asked the American Medical Association to modify its policy with respect to laboratory services. This request was implemented, and physicians were given the opportunity of ethically referring specimens to non-physician-directed laboratories.

Industry was watching these developments with interest. Research studies and marketing surveys indicated opportunities for industry in the laboratory and diagnostic field. One such study was prepared prior to the consent decree. One statement in this report is of interest: "If the government wins this suit—the first brought against a medical group since 1939—the result would have far-reaching effects on the definition of the practice of medicine and on the setting of standard fees by M.D.'s. Such an outcome would also challenge much of the physicians' ethical code. Another effect would be to make clinical and X-ray processing and analysis laboratories more attractive as commercial ventures."

It appeared for a time that the American Medical Association might be joined as a defendant in this antitrust action. This did not happen, but in 1968 in response to the threat, the AMA did approve the acceptance of advertising by industry-operated laboratories in medical publications of the AMA. There was much opposition to such advertising. These complaints were considered by the Judicial Council and a report of this Council was adopted which states the following:

"It is preferable that the laboratory, not the attending physician, bill and collect from the patient or third-party payor for laboratory services. Where circumstances make this impractical, or where increased cost to the patient would result, the bill submitted by the attending physician to his patient or to a third-party payor should state the name of the laboratory performing the services for his patient, and the exact amount of the charge paid, or to be paid, by the physician to the laboratory."

The Board of Governors of the Florida Medical Association subsequently ratified this AMA action, and the Florida Blue Shield Board of Governors adopted it as Blue Shield policy.

In 1967 the United States Congress enacted the Clinical Laboratories Improvement Act. This law required the licensure of clinical laboratories engaged in interstate commerce. The College of American Pathologists opposed this law because it was not necessary, citing the following reasons: (1) The American Society of Clinical Pathologists in 1957 had launched a comprehensive continuing education and quality assurance program by establishing the Commission on Continuing Education. (2) The College of American Pathologists in 1961 initiated its Inspection and Accreditation Program for Clinical Laboratories. Both programs were widely supported by pathologists and were very effective in improving the quality of laboratory services. The law was passed anyway.

About the same time, the Center for Disease Control began to promote licensing acts for clinical laboratories at the state level. A model act was developed which resembled the federal act and provided for the directorship of clinical laboratories by both physicians and non-physicians. In 1967 the Florida Clinical Laboratory Act was enacted by the Florida legislature. This Florida law required the registration of all independent and hospital laboratories and the licensing of technical personnel employed in them. Many laboratories were faced, therefore, with multiple sets of regulations which

were diverse in their requirements.

In 1975 an additional federal Clinical Laboratory Act to regulate clinical laboratories was introduced. This new proposed legislation was comprehensive and was applicable to hospital laboratories as well as independent laboratories. Physicians' office laboratories were excluded. Although reintroduced in each session of Congress since 1975, it has not become law. It has been changed substantially in recent years and bills currently under consideration have sections that apply to pathologists' reimbursement as well as quality control and personnel standards in the laboratory.

In 1972 Congress enacted some sweeping Social Security amendments. One of these amendments stated the following:

"For medical services, supplies, and equipment (including equipment servicing) which the Secretary has found do not generally vary significantly in quality from one supplier to another, the lowest charge levels at which such items and services are widely and consistently available in a locality shall be the upper limit in determining the reasonable charge." The Committee Report made it clear that this amendment applied to clinical laboratory services.

The Department of HEW had great difficulty in developing regulations to implement this amendment. Final regulations were published in 1978 with twelve laboratory procedures included. The lowest charge level was established at the 25th percentile of the prevailing charge in the area. Proposals for including additional laboratory procedures are currently under consideration by the Department of HEW.

In 1976 Senator Herman Talmadge introduced the Medicare and Medicaid Administrative and Reimbursement Reform Act of 1976. This bill was primarily a cost containment bill. It included a section on hospital-associated physicians. Pathology services were redefined in this section as follows:

"Pathology services shall be considered 'physicians' services' only where the pathologist personally performs acts or makes decisions with respect to a patient's diagnosis or treatment which require the exercise of medical judgment. These include operating room and clinical consultations, the required interpretation of the significance of any material or data derived from a human being, the aspiration or removal of marrow or other materials, and the administration of test materials or isotopes. Such services shall not include such services as: the performance of autopsies; and services performed in carrying out responsibilities for supervision, quality control, and for various other aspects of a clinical laboratory's operations that are customarily performed by nonphysician personnel."

Another portion of this proposed law would for practical purposes eliminate percentage contracts for hospital-based physicians.

The Talmadge bill has been reintroduced in each session of Congress since 1976. The College of American Pathologists, the AMA and other organizations have actively opposed several sections of the bill including that section that would redefine physicians' services.

At the time of this writing, both the House of Representatives and the U.S. Senate have Medicare/Medicaid reform under active consideration but the outcome has not been decided. The fate of the Talmadge bill with its redefinition of physicians' services, including the redefinition of pathologists' services, is unknown.

The Social Security Amendments of 1972 also included a section (Section 227) which provided new ground rules for reimbursement of physicians in teaching hospitals. These new ground rules were designed to eliminate some reimbursement practices by teaching hospitals that were thought to be inappropriate. They called for reimbursement to physicians in teaching hospitals under Part A of Medicare on a cost basis rather than on a fee for service basis. Fee for service would be continued only if a patient was a "bona fide private patient" or the hospital had traditionally charged all patients on a Part B fee basis and collected from a majority of them on such a basis.

Although regulations to implement Section 227 have been drafted, they have not yet been published in final form. The most recent draft would seem to effectively eliminate most if not all pathology services from the definition of physicians' services. Congress extended the grace period for implementation of these regulations until October 1, 1979. Whether an additional extension will be provided or whether Section 227 might be repealed, as has been suggested, is in doubt at this time.

In 1973 Congress enacted the Health Maintenance Organization Act (HMO Act). This new law was designed to promote an alternative or competitive health care delivery system to the fee for service system. Three types of HMOs were described in the law. In all three types subscribers prepay the cost of their health services by paying a monthly fee. There are now some 7½ million subscribers to 203 HMOs.

Experience with these HMOs has indicated that competitive bidding for laboratory services is commonplace, especially in the developmental stages of HMOs. If fee schedules are used, these fee schedules have generally been lower than those usually charged by the laboratory. Both industry and the federal government are actively promoting HMOs at this time. Since competitive bidding by Medicaid programs in many states is also becoming commonplace, pathologists should be prepared to provide services on a competitive bidding basis.

In 1975 Congress enacted the Health Planning Law.

This law set up a comprehensive system of health service agencies throughout the United States with broad powers to develop plans for health care delivery. Each Health Systems Agency must develop a health plan which is updated annually. Some of these plans have included clinical laboratory services. There is a distinct trend in this planning to centralize clinical laboratory services for both ambulatory patients and hospital inpatients on the premise that such centralization would reduce costs. The Health Planning amendments adopted by Congress in 1979 provide an exclusion from certificate of need requirements for independent clinical laboratories. This would suggest increasing interest on the part of Congress and HEW in this centralization of laboratory services concept.

The debate over national health insurance is so clouded at this time that it would be inappropriate to discuss the effect of national health insurance on pathologists.

In early 1979 the Health Care Financing Administration through its Regional Office in Philadelphia initiated efforts to limit reimbursement for pathology services to only those items that are personally performed or personally directed by pathologists. A series of meetings with representatives of the Health Care Financing Administration, the College of American Pathologists and the American Medical Association were held in an effort to get HCFA to continue present reimbursement policies for clinical laboratory services. In August 1979 HCFA provided the College of American Pathologists with a copy of proposed final regulations for reimbursement of hospital-based physicians. These regulations would for practical purposes eliminate all professional component billing and would have an adverse effect on percentage contracts between pathologists and hospitals. The College has responded to HCFA with strong objections to these proposed regulations and has asked that they not be published.

The Board of Governors of the College has also authorized the College officers and legal counsel to initiate legal action against the Department of HEW in case these regulations are published in final form.

It is obvious that reimbursement for pathology services is going through a very turbulent period and the outcome is unknown at this time. Pathologists may have become victims of their own success. Improvement in the quality of laboratory services and the availability of these services has increased the amount spent for them by government programs to the point that pathologists find themselves at the center of attention by both members of Congress and government bureaucrats. This is an uncomfortable position to occupy.

The history of pathology has always been turbulent, however, and pathologists are becoming more sophisticated in the political arena. The College of American Pathologists has a strong Washington office to represent it in dealing with big government and many pathologists over the United States are also active in politics and legislation.

The problems facing pathologists in dealing with government are the same as those of other physicians. The American Medical Association recognizes this fact and the positions it assumes are pretty much the same as those of pathologists.

Hospitals now have the same problems, so we find physicians and hospitals working together in dealing with government. Corporate practice by hospitals is rarely mentioned anymore.

Additional chapters in the history of pathology will soon be unfolding. I can hardly wait to find out what they say.

References are available from the author upon request.

• Dr. Coleman, 4600 North Habana, Suite 21, Tampa 33614.

Laboratory Medicine and Pathologists in Florida Prior to 1950

James N. Patterson, M.D., M.S. and Marsha J. Moore, B.A.

The history of pathology in the 1800's and in the first decade of the 1900's is rather sketchy. A paper by Dr. William M. Straight of Miami entitled "Calomel, Quinine and Laudanum, Army Medicine in the Seminole Wars" that appeared in the *JFMA* v. 65: pp. 627-643, August, 1978, is most comprehensive and is the source of most of our information in the 1800's. Dr. Straights' paper should be read by anyone interested in the history of medicine at that time. Since this Journal is readily available, only a few highlights of this article will be presented here.

No mention will be made in this paper covering pathology and its various aspects during the Spanish American War, World War I or World War II. For those interested, this information is available in the Surgeon General's reports.

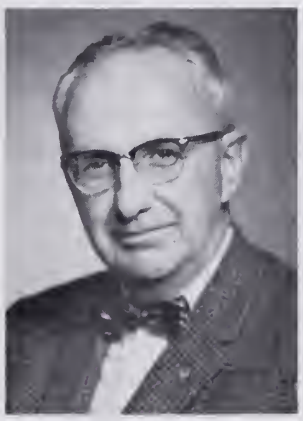
Judging from the comments of Major General George A. McCall in his "Letters From the Frontiers," autopsies were probably done at the army hospital in Pensacola as early as 1823. There was a microscope in this hospital but what use it was put to is not clear.

An early mention of the use of the microscope in the clinical laboratory appears in an address before the FMA on "The Germ Theory of Disease," by C.J. Kenworthy. This is published in the *Proceedings of the FMA* session April 15, 1879, page 68. Kenworthy, a Jacksonville practitioner, became president of the FMA in 1880-1881. Much to the amazement of the assembled doctors, he demonstrated bacteria growing in the urine, apparently using his own microscope.

There were a number of autopsies performed at the posts and in the general hospitals during the Seminole Wars. Fever and dysenteries were the most numerous and the most fatal diseases. Quinine was the favorite drug for fevers.

Splenomegaly was an infrequent finding and some physicians thought the use of quinine led to the diseased livers and enlarged spleens, or ague cakes, as they were called. Dr. Daniel Drake, a pioneer physician and a leader in medical education, rejected the concept that splenomegaly resulted from quinine therapy. He stated that, "If this ever happened it was because the lancet had not been adequately employed before resorting to that medicine (quinine) - the sooner the fever is checked the less the danger of the enlarged spleen."

Dr. Straight came across an autopsy reportedJune 30, 1846, by the Assistant Surgeon H.H. Steiner, at Fort



Dr. Patterson

The Authors

JAMES N. PATTERSON, M.D.

A resident of Tampa, Dr. Patterson is one of the pioneer pathologists in Florida. He graduated from the University of Cincinnati in 1928 and became Director of the Bureau of Laboratories of the Florida State Board of Health 10 years later. Before coming to Florida, he was Assistant Professor of Pathology at the University of Cincinnati College of Medicine. He was also consulting pathologist to the General and Bethesda Hospitals in Hamilton, Ohio. He became Assistant State Health Officer in 1941, served during World War II in the Air Corps, then returned to Tampa and established the Pathology Laboratory of Drs. Mills and Patterson. This evolved into the present day consulting and reference medical library known as Patterson and Coleman Laboratory, an affiliate of Smith Kline Pharmaceutical Co. Additional details of Dr. Patterson's career are included in the text of the article. In 1952 he was appointed as a trustee member of the American Board of Pathology and served on this Board for 14 years. He received the 1968 American Pathology Foundation Award for distinguished service to pathology.



Ms. Moore

MARSHA J. MOORE, B.A.

Ms. Moore is medical librarian for Smith Kline Clinical Laboratories — Patterson and Coleman Laboratory in Tampa. She holds a B.A. degree from the University of South Florida in Library Science and Audiovisual education. She will complete requirements for her M.A. degree from the University of South Florida this year.

Brooke. He reported that the death of a 23 year old man was apparently caused by a ruptured appendix with a large abscess that involved the lumbar spine, sacrum and ilium. Still another autopsy was reported by Assistant Surgeon B. W. Woods, at Fort Russell at Key Biscayne, on June 30, 1842. This patient supposedly died of congestive fever.

Another early autopsy was reported by John P. Wall of Tampa in 1884. This appears in Wall's article, "The Yellow Fever in Tampa, Plant City, Manatee and Palmetto," in a *Report of The Supervising Surgeon General of the Marine Hospital Service*, Washington, 1888-1889, pages 60-76. This was a case diagnosed as typhomalarial fever and an autopsy showed the typical intestinal lesions of typhoid fever.

The history of the Florida State Board of Health was published in the *JFMA* by Joseph Y. Porter, M. D., the first state health officer. The articles were entitled *"Looking Backward Over 50 Years of Health Work in Florida,"* and appeared in the *JFMA* serially in the issues of July through December, 1925, and in the January issue of 1926. Dr. Porter states that 10 years after the State Board of Health was created, a bacteriological laboratory was established. This was brought about largely by the influence of the Honorable W. S. Jennings, then Governor. This work was done in the laboratory at Jacksonville by a well-trained bacteriologist, Eduardo Andrade. The service was free and was appreciated by the medical profession and citizenry to such a degree that other bacteriological laboratories were requested to be located in other parts of the state. Branch laboratories were set up in Tampa, Pensacola, Miami, and Tallahassee, thus making history for the progress of the state in supervising the health of its citizens.

Most of the discussions in Dr. Porter's articles concerned the epidemics, the methods of combatting infections, and the introduction of laboratory procedures. Noted is the fact that tissues were farmed out for pathologic examination, but the names of the physicians doing these examinations were not given.

Northeast Florida

Probably the first physician in Florida to perform surgical pathology was James H. Hartman, [1,2] a surgeon at St. Luke's Hospital in Jacksonville in 1908. He graduated from the College of Physicians and Surgeons in Baltimore in 1904. A history of St. Luke's Hospital makes no mention of this fact, although it was noted that he was a resident physician and surgeon there from 1908 to 1910. He performed pathologic examinations on tissues he removed and occasionally did exams for other physicians. He also did autopsies. Hartman left the residency in 1910 and became one of Jacksonville's foremost surgeons, practicing at Riverside and St. Vincent's Hospitals. He died December 26, 1946, of coronary occlusion, age 66.

The first pathologist in Florida was Henry Hanson,[3] a John Hopkins graduate who came to Jacksonville to become the Director of the Bureau of Laboratories of the Florida State Board of Health. He opened a private laboratory in 1916. In 1918-1919, he served as a major in the United States Army and was assigned to the Canal Zone. In 1919, he became Assistant Health Officer with the Panama Canal Zone Health Department. His interest in tropical diseases took him to Peru in 1920, where he served the Peruvian Government as Director of Yellow Fever Control. After this assignment he was affiliated with the Rockefeller Foundation from 1923 to 1927. Dr. Hanson re-affiliated with the Florida State Board of Health in 1928 and, in 1929, became State Health Officer, a position he held until 1936. He then returned to various assignments in Latin America. In 1942, he was re-appointed State Health Officer and served in this capacity until his retirement in 1945. During his long career he published many papers on heart disease, rabies, pellegra and malaria. Governments of Peru, Ecuador and Cuba signally honored and decorated him. He was the founder and first president of the Florida Public Health Association. He died at his home in Jacksonville on December 13, 1954, following a brief illness, at age 76.

Iva C. Youmans, [1,2,8] was the next pathologist in the state, and was a graduate of John Hopkins in 1909. From 1910 to 1917, she served the Florida State Board of Health laboratories in Jacksonville, and was the only female physician in Florida at that time. In 1914 she went to Miami to establish a branch laboratory of the State Board of Health, and also opened a private laboratory in Miami. Youmans returned to Jacksonville as Pathologist to Riverside Hospital. She also gave anesthetics and performed various other clinical duties. She returned to Miami after a few years. Her story will be picked up when the lower gold coast is discussed.

William W. Kirk, [1,2] a graduate of the University of Pennsylvania in the class of 1921, opened a private laboratory in Jacksonville. According to the records of the Board of Medical Examiners, however, he was not licensed until 1923. He also headed the laboratories of the Duval County Hospital and St. Luke's Hospital, and was certified by the American Board of Internal Medicine. Kirk served the U.S. Naval Reserve Infirmary at Green Cove Springs, and later practiced as a civilian physician until 1941. He then served as a captain in the U.S. Navy from 1941 to 1954.

In the mid 1920's T. Z. Cason, [1,2] a prominent internist in Jacksonville, went to Chicago's Cook County Hospital and learned the current clinical chemistry procedures and established them at Riverside Hospital. He died June 28, 1968, of pulmonary thromboembolism

and peri-prostatic venous thrombi, at age 81.

Clayton E. Royce, [1,2] a graduate of Columbia University College of Physicians and Surgeons, became the first pathologist at the "new" St. Vincent's Hospital in Jacksonville. He was later joined by Lucien Y. Dyrenforth. Dyrenforth was a graduate of Emory University in 1930, and received an M.S. in pathology from the University of Illinois in 1931. He was chief of the Department of Pathology at St. Luke's, Riverside and Duval County Hospitals. The private practice of Drs. Royce and Dyrenforth covered the state from Pensacola to Key West and extended into southern Georgia and Alabama. Dyrenforth was the chief medical examiner for Duval County. He was also the founder of the Jacksonville Blood Bank and its first director. Dr. Royce died on February 12, 1947 from coronary occlusion. Dr. Dyrenforth died at Riverside Hospital on January 20, 1970, of uremia, nephrosclerosis and arteriosclerosis.

James N. Patterson, (the author), a 1928 graduate of the University of Cincinnati, came to Jacksonville March 1, 1938, as Director of the Bureau of Laboratories of the Florida State Board of Health. At that time there were only five other certified pathologists in the state; Mills, Youmans, Royce, Dyrenforth and Johnson. For health reasons he decided to move to Florida. When he was finishing his last examination of the Florida Board of Medical Examiners in November, 1937, he was advised that the State Health Officer wanted to see him. He was offered the directorship of the Bureau of Laboratories. He was given additional duties as Assistant State Health Officer in 1941. Patterson joined the U.S. Army Air Force as a major in 1942 and was assigned to the Army Air Force Tactical Center at Orlando as Chief of the Laboratories of the Regional Hospital. He was promoted to Lt. Col. after one year of service and was discharged in 1946, when he joined Dr. Mills in practice in Tampa.

Nelson A. Murray,[4] a native of Jacksonville and a 1939 Tulane graduate, joined Dr. Royce at St. Vincent's Hospital in 1944. Royce died shortly thereafter and Murray replaced him as pathologist. Murray left St. Vincent's Hospital in 1953 and opened a clinical pathology laboratory, serving a number of hospitals in the surrounding area as well as doing private laboratory work for Jacksonville physicians.

Southwest Florida

The pioneer pathologist in this area of Florida was Herbert R. Mills,[5] a 1910 graduate of Rush Medical College. He came to Tampa shortly thereafter and was made Director of the Tampa Branch Laboratory of the State Board of Health. He held this position until he joined the British Expeditionary Medical Force in 1917, and, when the United States entered the war, he transferred to the Army of the United States. He was stationed in Europe much of the time and in Germany with the Army of Occupation. On his discharge from the Army, he returned to Tampa and became pathologist to the Riverside Hospital, and later was affiliated with the Gordon Keller Hospital, which became the Tampa Municipal Hospital (now Tampa General Hospital). He also became pathologist to the Centro Espanol and Centro Austuriano Hospitals. Mills joined the Hillsborough County Medical Association in 1927 and founded The Laboratory of Clinical Pathology in 1928, which was located in the Citizens Bank Building. He served the lower west coast of Florida, receiving tissues from as far away as Fort Myers. Mills was the leading environmentalist and conservationist in this area and out of his own pocket paid the salaries and purchased supplies for two game wardens for bird sanctuaries on Whiskey Stump and on the Alafia bank.

On his discharge from the Army Air Force, Patterson became a partner of Dr. Mills and the name of the laboratory was changed to Drs. Mills and Patterson. Ira C. Evans,[6] a 1938 graduate of the Medical College of Virginia, joined forces with Mills and Patterson. It was soon evident that much time was lost in commuting to and from St. Petersburg and Tampa so the arrangement was discontinued and Evans remained in St. Petersburg where he was pathologist to Mound Park Hospital until 1971. He had private clinical laboratories then, and still is active in private clinical laboratory work. Dr. Evans was in the Army of the United States from 1940 until 1946 serving in this country, then in Africa and in Italy.

Millard B. White,[7] a 1935 graduate of Duke University, worked with Drs. Mills and Patterson and at Duke University of Pathology, preparatory to examination by the American Board of Pathology. He was pathologist to the Sarasota Municipal, Venice Memorial, Manatee Memorial and Doctor's Hospitals. White and his group were affiliated with Smith Kline Laboratories for a few years. This affiliation was terminated and the group now serves Sarasota and Doctor's Hospital. White continues his work chiefly as Medical Examiner for Sarasota County. Dr. White was in the Army Air Force and was chief of the laboratory at McDill Air Force Base in Tampa from 1941-1946.

Dr. Mills resigned his position as pathologist to the Tampa Municipal Hospital in 1949 and was succeeded by Sydney S. Schochett,[2] an obstetrician and gynecologist who graduated from Tulane in 1914. He only stayed for a short time and was succeeded by Wray D. Storey, a 1939 graduate of Duke University. Storey left Tampa in 1959 for practice in Odessa, Texas. He is still in practice but plans to retire within the year. Dr. Mills died of acute leukemia in June, 1952. Dr. Schochett died April 28, 1965, of cerebrovascular accident and arteriosclerotic cardiovascular disease, age 75.

After Dr. Mills' death, Patterson had several

partners. The first was James B. Leonard, a 1944 graduate of Jefferson Medical College, and now pathologist to Morton Plant Hospital and Medical Director of the Hunter Memorial Blood Bank in Clearwater. Following were Charles Catanzaro, a 1946 Jefferson Medical College graduate, now inactive because of a medical disability, and William Eckert, a 1952 graduate of the New York University, now practicing in Wichita, Kansas. When Frank C. Coleman, a 1941 graduate of Tulane, joined Patterson, the lab became known as Patterson and Coleman Laboratory. In 1970, this laboratory affiliated with Smith Kline Pharmaceutical Company of Philadelphia. The laboratory is now known under both names.

Following a triple saphenous vein aorta coronary bypass operation, Patterson retired from practice in February, 1971. He still, however, comes to the laboratory daily. Coleman retired as Director of the laboratories in 1977. He is now consultant for legislative and regulatory affairs for all of the Smith Kline Laboratories. He is also available for private consultation.

John W. Williams, [11,2] a 1920 graduate of Washington University in St. Louis, was pathologist at the Morrell Memorial Hospital (now Lakeland General Hospital) in the late 1940's, and remained there for a couple of years. He died in St. Petersburg on June 9, 1976, of a cerebral infarction.

Upper Gold Coast

Vernon Meadows Jared [11,2] graduated from Hahneman Medical College of Chicago in 1912, and came to West Palm Beach as pathologist at the Good Samaritan Hospital. While at his alma mater he was Associate Professor of Pathology. He was licensed to practice medicine in Florida in July, 1927. Dr. Jared died February 27, 1931, following an operation for appendicitis.

V. Marklin Johnson[9] graduated from Tulane Medical College in 1929. After receiving his residency at the Touro Infirmary in New Orleans, he settled in West Palm Beach. He became pathologist and Director of the Department of Pathology at the Good Samaritan Hospital and was pathologist later at St. Mary's Hospital. He was instrumental in the founding of the West Palm Beach Blood Bank, Inc. and was medical director from 1938 to 1966. Johnson was also Chief of Staff of Good Samaritan Hospital. He is still active at Good Samaritan Hospital and in private clinical laboratory work.

Lower Gold Coast

Dr. Youmans [1,2] left Jacksonville and returned to Miami and resumed her private clinical laboratory in the early 1920's. She is listed in the 1925 Jackson Memorial Hospital Nursing Annual as a bacteriologist, and in the 1929 and 1930 editions as a consulting pathologist. Her private laboratory served physicians in the Bahamas and in British Honduras as well as in the Miami area. She retired from practice at age 77. Her last few years were spent in a nursing home where she died on December 23, 1973, of cardiac failure, at age 95.

Dr. Youmans informed William Straight, M.D. that the first full time pathologist at Jackson Memorial Hospital was Joseph Matthieu.[11,2,8] His original name was Oscar Kanner and he was graduated from the University of Vienna in 1921. Kanner had his name legally changed in the Dade County Circuit Court to Joseph Matthieu. His license to practice medicine in Florida was issued December 1929, and he is listed in the 1930 Jackson Memorial Hospital Nursing Annual as pathologist. Unfortunately, most of the Jackson Memorial Hospital Nursing Annuals for the 1930's are missing from the library, so it is not known how long he served as pathologist to J.M.H. The information as to when he left Miami is not available but he was located by the State Board of Medical Examiners at the V.A. Hospital in Oteen, North Carolina, in 1961, under his original name of Oscar Kanner. He died in Asheville, North Carolina August 14, 1965, of chronic leukemia, diabetes mellitus and chronic pulmonary tuberculosis.

The exact dates and duties of the physicians listed below may not be correct but is the best information available. In the 1928 and 1929 Jackson Memorial Hospital Nursing Annual is listed the name of W. P. Stowe [2,8] under the designation of chemistry, pathology and bacteriology. Washington Parker Stowe was a 1918 graduate of the University of Michigan. He was also on the staff of St. Francis Hospital. Dr. George S. Palmer, Executive Director of the Florida State Board of Medical Examiners, personally searched the files and found no evidence that he ever received a license to practice medicine in Florida. It has been reported that he was the first full time pathologist at St. Francis Hospital at Miami Beach. He died September 14, 1950, of illuminating gas poisoning (self-administered).

Also listed as a consulting pathologist to J.M.H. was A. Buist Litterer, [2,8] a 1923 graduate of Vanderbilt University. He was certified by the American Board of Dermatology and Syphilology and was Director of the Department of Dermatology of J.M.H. He was listed as Assistant Professor of Dermatology of the University of Miami School of Medicine. Litterer served as a Commander in the United States Navy from 1941 to 1945. He died January 1, 1959, at age 61.

Also listed as consulting pathologist was W. H. Watters, [2,8] a 1900 graduate of Boston University. He was Professor of Pathology at his alma mater from 1903 through 1925, and Professor of Preventive Medicine in 1925 to 1935. Watters was a diplomat of the American Board of Internal Medicine and was a Fellow in the

American Society of Clinical Pathologists. He was past president of the Massachusetts Medicolegal Society and was an Associate in Legal Medicine at Harvard. He was a member of the staff of St. Francis Hospital in Miami Beach and was the founder and director of the Boston-Miami Hospital in Coral Gables. He died October 11, 1949, of coronary thrombosis, at age 73.

Alfred Levin [11, 2, 8] was a 1930 graduate of the University of Minnesota. He had his residency training in radiology at the Presbyterian-Columbia Hospital in New York City and was certified in radiology by the American Board of Radiology. He was pathologist at Jackson Memorial Hospital from 1938 to 1940. Levin was a Lt. Col. in the Army of the United States from 1942 to 1946. He was a Clinical Professor of Radiology at the University of Miami School of Medicine. He died May 31, 1978, of a drug overdose.

Phillip Rezek, [8, 2] a 1921 graduate of the University of Vienna, became a resident in pathology at the Jackson Memorial Hospital under Alfred Levin from 1938 to 1940. He came to Miami via Havana, Cuba. In 1940 he became the pathologist to the Jackson Memorial Hospital, although he was not licensed to practice medicine in Florida until 1949. There were two objections that prevented his being admitted to examination by the Board of Medical Examiners; one regarded his post-graduate training, the other, more importantly, he was not a United States citizen. At that time it was a requirement that the candidate must be a full citizen of the United States to be admitted to the examination-not just an intent to become one. Senator George Smathers got a bill through the Florida legislature making him a United States citizen. He was then permitted to take the examination in 1949. Later he became Clinical Professor of Pathology at the University of Miami School of Medicine. He died in Miami on June 23, 1963.

Alfred E. Cronkite, [11, 2] a 1938 graduate of Stanford University, became pathologist at the Broward General Hospital in Fort Lauderdale in 1944. He later became consulting pathologist to the Memorial Hospital in Hollywood. He died September 27, 1957.

Maxwell M. Sayet,[12] a 1934 graduate of the University of Bellevue Medical School, came to Miami Beach in 1947 as pathologist to the Alton Road Hospital and later Mt. Sinai Hospital in Miami Beach. He later became pathologist to the Doctors Hospital in Coral Gables. He also has a large private clinical laboratory there. Sayet was in the Army of the United States for three years, most of which was served in the European Theater Operations.

Frederick H. Dietrich, [11, 2] a 1910 graduate of Columbia University, became the next pathologist at St. Francis Hospital in Miami Beach, but a short time later, left and joined the Army Air Force. He served as a major and was stationed as the Chief Laboratory Officer at Barksdale Field, Louisiana, where he died February 16, 1944, of coronary occlusion.

The next pathologist at St. Francis Hospital was Milton G. Bohrod, [13, 11, 2] a graduate of the University of Illinois in 1927. He served as pathologist of St. Francis from January, 1940 until September, 1942. He is now retired and lives in Rochester, New York.

Robert J. Poppiti,[14] a graduate of Long Island Medical School, was the next pathologist at St. Francis Hospital, serving from 1945 to 1956. At the same time he was Chief Medical Examiner for Dade County and consulting Pathologist to Variety Children's Hospital, Children's Cardiac Hospital and the V.A. Hospital in Coral Gables. In 1956, he became pathologist to Broward General Hospital in Fort Lauderdale. He is also Chief Pathologist to the Broward General Medical Center of the North Broward Hospital District, and Consulting Pathologist to the North Broward Hospital.

Northwest Florida-The Panhandle

E. H. Ruediger, [11, 2] a graduate of Rush Medical School, obtained his license to practice medicine in Florida and became pathologist to the Florida State Mental Hospital at Chattahoochee in 1940. He was the author of a complement-fixation test for syphilis using human red cells instead of sheep red cells. This technique, however, never became popular. Apparently he did not stay long and moved somewhere out west. All of the records of the State Mental Hospital are in the Archives at the capitol in Tallahassee and are not available. His last known address was Long Beach, California. He died June 22, 1965.

The second pathologist in this area was William Spears Randall, [11, 2] a 1937 graduate of Tulane. He was pathologist to the Pensacola Hospital from 1940 to 1942. From 1942 to 1946, he was in the Army of the United States. He was officer in charge of pathology and, from 1945 to 1946, was also Chief of the laboratory service at Walter Reed Hospital, Washington, D.C. When he left the service he went to Baton Rouge, Louisiana, and New Orleans. He was head of the Department of Pathology at the Oschner Clinic in New Orleans from 1948 to 1952. He died in Baton Rouge September 15, 1975, of atherosclerotic cardiovascular disease.

The next pathologist in this area was Gretchen Squires,[15] a 1938 graduate of Louisiana State University, who came to Pensacola at the end of World War II. She was pathologist at the Pensacola Hospital, Escambia General Hospital, the Baptist Hospital, and also had a private clinical laboratory. In 1959, her husband Raymond, who also had his Ph.D. in chemistry, took a residency in pathology at Mt. Sinai Hospital in Chicago, and at the Baptist Hospital in Pensacola. He became certified in clinical pathology in 1962. Both of the Drs.

Squires are retired.

Clarence W. Ketchum,[16] a 1930 graduate of Emory, became a pathologist to the Tallahassee Memorial Hospital in 1949, and later established a private clinical laboratory. He is now semi-retired, working only in the mornings. Ketchum was in the U.S. Army for six years, going from Lt. to Lt. Col. Ketchum was chief of the laboratory at Cushing General Hospital in Massachusetts.

Central Florida

H. Asa Day,[2] a gynecologist and a 1923 graduate of the University of Cincinnati, did the pathology at the Orange Memorial Hospital until the advent of George R. Kerr. Day had one year of pathology at the Cincinnati General Hospital and served on the Florida State Board of Medical Examiners. He died February 20, 1967, of coronary artery thrombosis.

George Russell Kerr,[17] a graduate of Western Ontario Medical College in 1936, was licensed to practice medicine in Florida in 1942. He was pathologist at the Orange Memorial Hospital from 1942 to 1952. He resigned his position and went to the Alamance Memorial Hospital in Burlington, North Carolina, where he remained until his retirement two years ago. He is in good health and enjoying his retirement.

Leon Lippincott [11,2] graduated from the Medical College of Maine in 1913, and was pathologist at the Halifax District Hospital from 1947 unti his death at 62, on November 25, 1950. He died of phlebitis and pulmonary embolism.

Author's Supplemental Note:

Getting this data has been a monumental task requiring hundreds of hours of work. It was very frustrating requesting information and to have the request ignored, often requiring duplicate letters and, in many instances, repeated telephone calls.

We are sorry that it was not possible, because of the length of this paper and the time required, to bring this review up to the present time. We hope that someone will complete this task. We also hope that we have not missed anyone in this review and that our information was factual.

References are available from the authors upon request.

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Interact Series Or "As Others See Us"

Introduction

At a time when some pathologists may wonder about their roles and places in the practice of medicine and the care of the sick, a group of articles, "As Others See Us," seemed to the Editors of this Special Issue to be a worthwhile contribution. If it is true that a person is what he **thinks** he is, what **others** think he is, and what he **really** is, perhaps a clarification of how others think we are may help to elucidate the other two portions of the equation.

The series includes articles by a general surgeon, an obstetrician and gynecologist, a dermatologist, an internist-gastroenterologist, and a hematologist-oncologist. We believe this selection is broad enough to encompass a significant percentage of the specialists and other practitioners of medicine who come into contact with pathologists through their daily efforts.

We wish to thank all the authors for their candid and valuable contributions to our issue.

The Editors

(Continued on page 103)

The Pathologist and the Surgeon

Rufus K. Broadaway, M.D.

The Surgical Pathologist may be, as some would say, a frustrated surgeon. More likely, he, or she, is a surgical personality who was smart enough to become a pathologist. Whichever, he must possess those surgical qualities: determination, perseverance, compulsion, strength in the face of adversity, dominance, a sense of perfection, decisiveness, a pleasure in the thrill of movement.

The relationship between surgeon and pathologist is uniquely synergistic. Each depends to a considerable degree upon the skills and objectives of the other; and each must know the other's limitations as well as the opportunities for diagnosis and possibilities of success in treatment.

A surgeon may get along without ever speaking to a pathologist. His patients will suffer thereby. The concept of having the pathologist look only at the tissue, unhampered by clinical data, is a purist philosophy of yesteryear. We are impressed that a pathologist, given the most pertinent clinical data, can provide the most comprehensive opinion.

What, then, should a surgeon expect of his pathologist? He first expects the kind of instantaneous response that he demands of himself. Generally, a waiting surgeon is an unhappy surgeon. He expects a full appreciation of his problems and of what he is trying to achieve in his particular area. He expects precision, in weights and measures, in description and numbers. It is the smallest gallstone that is of interest, not the largest; the number of nodes and their cancerous involvement at each level, not the total amount of axillary fat. He expects that his colleague will pursue, through his fund of special studies, those maneuvers which will give the greatest accuracy to the diagnosis. He expects that consultation will be used freely, within department or community. He expects scrupulous honesty; a "freebie" diagnosis of "early acute appendicitis" is an insult to any self-respecting surgeon. A good surgeon should not have to tolerate a poor pathologist; although the converse is sometimes true.

And, conversely, what should be expected of the surgeon? The pathologist should be regarded by the surgeon as a skilled consultant who is most valuable if fully informed. A conversation about the clinical problem makes the pathologist a concerned member of the team. The pathologist can expect some understanding of his own problems. The surgeon must provide enough tissue, in proper preservation or in fresh state, from which a diagnosis can be made. Determination of who will take cultures, do smears or impressions, must be made ahead of time. The surgeon must not expect a "shoot-from-the-hip" diagnosis, regardless of the problem involved. It takes a gutsy pathologist to tell a harried, crusty, ill-tempered surgeon that a diagnosis cannot be made on frozen section, or that more tissue must be provided—just as the surgeon has closed the wound.

The relationship between surgeon and pathologist, then, is an intimate one, involving the best of communication, cooperation, and understanding. Each will benefit, as will the patient.

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The Past Twenty Years
A Premarital Intercourse

James L. Borland Jr., M.D.

In Boyd's textbook of pathology, published in 1954, only one and a half pages were devoted to descriptions of Crohn's disease, Whipple's disease and cholera. No microscopic description of nontropical Sprue was given and the disease was not mentioned as occurring in adults. Because adequate fresh specimens of tissue were not available for study, intestinal diseases were generally unrecognized or ignored. As a result, the only significant interfaces between pathologists and gastroenterologists prior to the early 1960's were the study of liver disease

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and gastrointestinal tumors.

With the introduction of the multiple purpose intestinal biopsy instruments (Crosby and Shiner capsules and the Rubin biopsy tube), an exciting era of investigation began. For the first time, using fresh non-autolyzed specimens obtained from the use of these revolutionary instruments, the normal histology of the stomach, small intestine and proximal colon could be studied. Correlation was established between clinical syndromes and alterations in the normal appearance of the bowel, and the histopathology of non-tropical Sprue, Whipple's disease, Crohn's and cholera soon was described. Subsequently, the implications of Giardia lamblia infestation, intestinal involvement in alphabeta-lipoproteinemia, gastrocolic fistulas and the blind loop syndromes were unfolded. With the rapidly advancing techniques of processing, the advances in electron microscopy and the capacity for taking multiple biopsies, a need for a close working relationship between, and cross-education of, gastroenterologists and pathologists became obvious. Joint discussions as to location of biopsy sites and techniques for preserving and orienting the small specimens obtained were required for biopsy interpretation.

The rapid increase in knowledge, and the developing interest in histopathology by gastroenterologists, at first brought friction and a certain amount of "turf protection" between pathologists and gastroenterologists. Happily, as both disciplines came to recognize the advantages of cooperation, conferences replaced confrontations at the gastroenterology-pathology interfaces.

As in many other areas of medicine, for both basic and clinical research to proceed, a common stand is clearly needed to confront the legal, financial, and administrative obstructions which are often arrayed to inhibit needed investigation. These restraints on progress can best be overcome by education and close cooperation between gastroenterologists and pathologists. This relationship is also needed to allow meaningful adaptation of the information explosion in the basic sciences to clinical problems in medicine. To paraphrase the late Dr. Julian Ruffin of Duke University, one cannot practice good gastroenterology without a good, interested pathologist.

The twenty years of intercourse has led to a marriage which should be, and hopefully will be, a long and happy one.

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How Dermatologists View Pathologists

Terrence A. Cronin, M.D.

The relationship between Dermatology and Pathology has always been rather a special one. As most Pathologists are aware, all Dermatologists train in Dermatopathology during the three years of their Residency. Many Dermatologists actually do their own pathological examinations, rendering reports and charging for this service. However, in many instances, biopsies that are performed in the office are sent to General Pathologists or specialized Dermatopathologists to read and these reports sent to the office, so that the two doctors work hand in hand. It is probable that Dermatologists perform more biopsies needing pathological examinations than any other specialty. In the average dermatological office, multiple small surgeries are performed daily. One well-known Florida Dermatologist sends over 100 specimens a week to his local hospital for pathological examination. Because of the Dermatologist's special training in Dermatopathology, he often will read the slides in collaboration with the General Pathologist. It is a generally held opinion that Pathologists are far more advanced in the diagnosis of tumors arising in the skin, but that in many instances, subtle nuances of inflammatory diseases of the skin are better diagnosed by the strict Dermatopathologist. Because of their similar interest in this fascinating subject, the relationship between Dermatologist and Pathologist has always been a good one, and we are hoping in the future that this relationship will broaden, to the mutual benefit of both of the specialties.

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An Oncologist's View

Robert C. Seelman, M.D.

As an internist with subspecialty Boards in Oncology, a pathologist is essential to my practice. My demands on a pathologist cover the complete gamut and truly test his/her versatility. From a purely laboratory viewpoint, the absolute quality of complete blood counts and platelets are essential for chemotherapy and also for the diagnosis and treatment of leukemia and other neoplastic disorders. This creates a special demand on the clinical hematology section, since quite often the smears are bizarre, at times almost defying interpretation, and the parameters of counts are most unusual. Pari passu with this is the necessity of frequent bone marrow examinations and bone marrow biopsies, which are reviewed jointly by the clinician and the pathologist. This helps to add to our understanding of a disease process, appreciate the toxicity of the drugs, and plan a sensible therapeutic course.

Removed from the hematology sector is the ever-increasing, burgeoning field of markers. There has been a veritable explosion in interest in this area, with the appearance of CEA's, Alpha-Fetoproteins, Chromosome studies, and HLA's, etc. The significance of estrogen receptors in the therapy of breast carcinoma offers great promise in our approach to therapy.

The processing, preparation and interpretation of tissue is again extremely important and falls almost directly in the purview of the pathologist. The proper selection of therapy, including irradiation, chemotherapy, or no therapy, depends so often on the exact interpretation of this material.

Unfortunately, in my field of oncology, there is a high incidence of demise from the primary neoplastic disease. By sharing with the pathologist the findings at necropsy, we are again better able to appreciate the natural history of the process as well as what inroads our therapy has made in its evolution.

To me, the pathologist must be truly a renaissance man exhibiting a wealth of information and skills necessary to satisfy the oncologist's needs. I cannot think of any other specialty more directly aligned with this necessary expertise than oncology.

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Pathology's Influence on Current Obstetrical and Gynecological Practice

Arthur E. Corey, M.D. and Seth J. Corey

In devoting this issue to the advancements in clinical medicine made by pathologists, *The Journal* is attempting to remedy the state of crisis engendered by the reign of technology.[1] Critics condemn scientific medicine for dehumanizing medical care with its emphasis on the patient as a disease. Examining that crisis before it came to the fore, Feinstein remarked:

> Clinicians who still believe that the main goal of clinical medicine is to prevent illness and to care for sick people, and pathologists who still believe that the main goal of pathology is to study human disease, can advance medical science now, more than ever, by collaborative research.

By working together, clinicians and pathologists can clarify the "present obscurity of natural history, prognosis, treatment, and many other features of human ailments."[2]

Dr. Corey is an Obstetrician-Gynecologist in Orlando and Seth Corey is a second year medical student at Tulane Medical School in New Orleans.

This all-too-brief review offers examples of collaboration between pathologists and Ob-Gyn clinicians that have improved management of common Ob-Gyn problems or have shed further light on these problems which may enable better management in the near future. Among these problems are: maternal pathophysiology, assessment of fetal maturity, genetic disorders, endocrine disorders, iatrogenesis associated with exogenous estrogens, and gynecologic neoplasia.

Obstetrics

Maternal Pathophysiology

Although it does not differentiate hCG from LH, radioreceptor assay (RRA) for hCG provides accurate diagnosis of early gestation. Albeit expensive due to a need for a gamma counter, this test can be used for patients desiring early termination of pregnancy or infertility patients anxious for early confirmation.[3]

A review of 501 maternal deaths in Texas during the period of 1969 to 1973 demonstrated the importance of hemorrhage, infection, and toxemia. Sixty percent of the deaths were due to obstetric causes, and a quarter of deaths occurred to women over the age of 35. Prenatal care was either lacking or very poor in almost a third of the cases; women of low socio-economic status accounted for 75% of deaths. The authors concluded that most of the deaths due to toxemia could have been prevented by successful contraception.[4]

In the *1977 Pathology Annual*, Ober reviewed experimental toxemia and offered several lines of investigation which deserve further attention, namely the renin-angiotensin-aldosterone system, a "thromboplastin-like" substance in uterine venous blood, and the presence of immune complexes within glomerular basement membrane and necrotic foci in the liver.[5]

Assessment of Fetal Maturity

Many investigators, including Spellacy, while he was at Gainesville, have demonstrated the accuracy of high lecithin-sphingomyelin ratio in predicting fetal maturity as well as a low ratio in predicting a neonate's susceptibility to respiratory distress syndrome.

In addition to its use in detecting neural tube defects, alpha-fetoprotein in abnormally high concentrations in maternal serum, perinatally, has been shown to indicate fetal hepatic immaturity and its possible sequelae hyperbilirubinemia.[6]

Genetic disorders

Investigators from Copenhagen to Japan have noted a discerning trend in younger mothers' presenting Down syndrome infants.[7] Nonetheless, trans-abdominal amniocentesis provides accurate diagnosis of that syndrome as well as most of the other chromosomal disorders, many inborn metabolic errors, and the open neural tube defects.

Gynecology

Endocrine disorders

The 1978 Nobel Prize in Physiology and Medicine recognized the tremendous impact of radioimmunoassay (RIA) in endocrine research. Besides awarding Yalow her prize for her role in developing the technique, the Nobel committee recognized Guillemin and Schally for their use of RIA in discovering hypothalamic hormones, one of which, Gonatropin Releasing Hormone (GnRH) may allow for a safer contraceptive in the near future. RIA has also aided diagnosis in pituitary disorders, such as hyperprolactinemic amenorrhea.

Enzyme immunoassay (EIA) has recently come into existence in laboratory diagnosis. EIA possesses distinct advantages in cheapness, sensitivity, and reagents with a long shelf life.

Iatrogenesis associated with exogenous estrogens

Among the most controversial issues in clinical medicine today is estrogen therapy for post-menopasual women. Exogenous estrogens have been implicated in the increased incidence of endometrial cancer, thromboembolism, coronary disease, and stroke.

Dangerous side effects have also been noted among women using the oral contraceptives, prompting the FDA to remove sequential pill from the market. Among these life-threatening side effects are: primary liver tumors, endometrial cancer, breast neoplasia, and cardiovascular disease. Risk factors for the cardiovascular disorders include history of smoking, length of exposure, and age.

These past five years have also seen conclusive proof of the association between in utero exposure to diethylstilbesterol (DES) with rare congental cardiovascular abnormalities, clear cell adenocarcinoma of the vagina or cervix and other epithelial abnormalities of the female genital tract. The long latency period characterizes the insidiousness of DES exposure.[8]

Gynecologic neoplasia

Estrogen receptor assay in primary breast tumor can provide information for better therapeutic management as well as in making more accurate prognosis. A conference sponsored by the National Institute of Health has just recently recommended that estrogen receptor assay of breast tumor tissue should become standard practice.[9]

References are available from the authors upon request.

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Recent Advances in the Clinical Hematology Laboratory: The Diagnosis of Anemia

Arnold H. Bierman, M.D.

Recent advances in the clinical hematology laboratory aiding in the identification of anemia revolve around the development and widespread availability and utilization of instruments capable of multi-parameter cell counting and concentrations, principally by a combination of electronic particle counting or light or laser beam scatter counting, and simultaneous measurement of hemoglobin concentration followed by electronic calculation of other parameters.

The first, and currently most widely used multiparameter counter, is the Coulter Model S(*) which quantifies seven items of a "CBC" - red blood cell count, hemoglobin, hematocrit, red cell indices (mean corpuscular volume, mean corpuscular hemoglobin and mean corpuscular hemoglobin concentration) and white blood cell count. Besides the obvious attribute of enabling all of these parameters to be performed much more rapidly compared to manually, precision of the resulting determinations has dramatically improved, even over the classical hand "reference methods." For example, red blood cell count utilizing the Thoma glass pipette and double chamber hemacytometer has a coefficient of variation of 16%, whereas electronic particle counting has a coefficient of variation in the 2% range. Examples of other instruments performing similar functions are the Hycel 500 or 700 (+), and the Hemac 630L. (X)



Dr. Bierman

The Author

ARNOLD H. BIERMAN, M.D.

Dr. Bierman is Associate Pathologist at Orlando Regional Medical Center, where his primary responsibilities are in hematology, chemistry and nuclear medicine. He is a graduate of the University of Missouri School of Medicine, and received his pathology training, including postdoctoral fellowship, at Yale University School of Medicine. He is active in the Orange County Medical Society, having served as Chairman of the Drug Abuse and Comprehensive Health Planning Committees.

The next generation of electronic counters is now making its appearance. Examples of these are the Coulter S-Plus, (*) the Ortho ELT-8, (X) the Hemalog-8, (#) and the Ultra-Logic 800. (&). These add improved or simplified hydraulics and electronics, enabling greater dependability, microprocessor control and self-diagnosing of malfunction checking by the technologists, the additional capability of adding platelet counts to the CBC, in some systems utilizing the same whole blood sample instead of requiring separation of plasma containing platelets from the other formed elements (RBC's and WBC's).

As a result of the above developments, truly "complete" blood counts are routinely available and performed rapidly. This, along with the greater accuracy and precision of the results,which is a function not only of the instrumentation, but also of the widespread availability of calibrators ("standards") and quality control material, enables early direction on a morphological basis of the nature of the anemia.

Hypochromic and/or Microcytic Anemias

Iron deficiency anemia is of widespread incidence affecting 50% of pregnant women, 30% of preschool children, 12% of adult women and 3% of adult males.[1] Three stages of iron deficiency are identifiable.[2,3] First, iron depletion due to mobilization from stores; second, iron deficient erythropoiesis due to lack of iron for heme synthesis in which anemia is not yet manifested; and third, detectable iron deficiency anemia. Of significance the anemia is initially normochromic and normocytic, then becomes microcytic and eventually microcytic and hypochromic.

Several developments or advances in the laboratory have occurred which assist in this diagnosis. First of all,

(*) Coulter Electronics, Inc., Hialeah, Fl.
(+) Hycel, Inc., Houston, TX
(X) Ortho Instruments, Westwood, MA
(#) Technicon Instruments, Tarrytown, NY
(&) Clay Adams, Division of Becton-Dickenson and Co., Parsippany, NJ

over the last ten to fifteen years has been the significant improvement in colorimetric methods for the analysis of serum iron. Basically, these have involved finding reagents with superior sensitivity for complexing with iron, such as sulfonated bathophenanthroline,[4] 2,4,6-tripyridyl-S-traizine (TPTZ), and ferrozine.[5] The significance of these improvements has been that, before they occurred, methods for measuring iron in serum lacked sensitivity in the low ranges, i.e. the ranges diagnostic for iron deficiency; therefore discrimination between normal and abnormal was poor.

The most recent advance aiding in the diagnosis of iron deficiency has been the development of a sensitive immunoradiometric assay for ferritin[6] and its demonstration as a normal constituent of serum and circulating red blood cells. In healthy adults the concentration of ferritin in serum is directly related to the available storage iron in the body. The mean concentration is higher in men than in women with a range between 12 and 250 mcg/1.[6,7] In patients with iron deficiency anemia concentrations are below 12 mcg/1 (Fig. 1). The advantages of the immunoradiometric assay are its quantitative and reproducible results together with its increased sensitivity in detecting low iron stores as compared with visual histochemical evaluation. In many cases in which no Prussian blue staining iron can be seen, concentrations of circulating ferritin may still be normal.[8] Changes in reticulo-endothelial iron (storage iron) are followed rapidly by changes in the serum concentration of ferritin. In normal subjects undergoing venesection the serum ferritin concentration falls rapidly as stores are mobilized.[7] Thus the measurement of serum ferritin has considerable advantages over the estimation of serum iron in the diagnosis of iron deficiency and in some cases may relieve the patient of the need to have a bone marrow aspiration when this is carried out purely for the assessment of iron status.[9]

Another hypochromic anemia which may be confused with iron deficiency, morphologically, is thalassemia minor. In many parts of the world and in many communities of North America the frequency of Beta thalassemia minor is second only to that of iron deficiency as the cause of hypochromic microcytic anemia. However, in nearly 85% of patients with thalassemia minor the erythrocyte count is greater than 5 million/microliter despite low hemoglobin concentration. In contrast, only about 3% of adults with iron deficiency anemia have erythrocyte counts of 5 million/microliter or higher. The mean corpuscular volume is almost always reduced in thalassemia minor with values of 55-70 um^3. Values this low are seen only in severe iron deficiency anemia. Some proposed rules[10] can separate iron deficiency from thalassemia minor with 90% accuracy when groups of iron deficiency and thalassemia patients are of nearly equal numbers. However, in a population in which iron deficiency is more prevalent than thalassemia minor, use of these criteria would result in a significant number of erroneous diagnoses. These rules are seen in Fig. 2.

Figure 2

1. —DF (=MCV—[5xHb]—RBC). Values are greater than 8.4 in iron deficiency anemia, 8.4 or less in thalassemia minor.*

2. —The ratio of MCV to erythrocyte count (in millions/ul) is greater than 14 in iron deficiency anemia, 14 or less in thalassemia minor.

3. —The ratio of MCH to erythrocyte count (in millions/ul) is greater than 4.4 in iron deficiency anemia, 4.4 or less in thalassemia minor.

4. —The erythrocyte count is less than 5 x 10 6/ul. in iron deficiency anemia, 5 x 10 6/ul or greater in thalassemia minor.

*DF=Linear discriment function.

	Serum Ferritin	Marrow Iron	Serum Iron	TIBC	Hemoglobin
Iron Deficiency:					
Stage I - Iron Depletion	↓	↓	N	N	N
Stage II - Deficient Erythropoiesis	↓	↓	↓	N-↑	N
Stage III - Anemia	↓	↓	↓	↑	↓
Anemia of Chronic Disease	N-↓	↓	↓	N-↑	↓

Fig. 1. —Stages of iron deficiency vs. anemia of chronic disease (TIBC= total iron binding capacity, N=Normal, ↑ = increased, ↓ = decreased).

Definitive diagnosis of Beta thalassemia trait has been made practical in the laboratory in recent years through the development of microchromatography using DEAE-cellulose and inexpensive glassware.[11] Normal levels of hemoglobin A-2 are 1.6 to 3.2 per cent of the total hemoglobin and in thalassemia minor the levels range from 3.5 to 7 per cent. Attempting to quantify hemoglobin A-2 by the usual methods of hemoglobin electrophoresis are either too cumbersome for the routine laboratory or inaccurate. It should be kept in mind if a patient has Beta thalassemia trait as well as severe iron deficiency, the hemoglobin A-2 may be in the normal range due to reduction in the A-2 value secondary to iron deficiency.

The importance of identifying thalassemia minor as the cause of microcytic anemia is two-fold: first, to avoid unnecessary treatment with iron and second, to be able to genetically counsel the patient as to the probability of passing the trait on to their children or the probability of having offspring with thalassemia major, if the patient's spouse also is a carrier of the trait.

Malignant or infectious diseases or other inflammatory conditions may result in anemia which most often is normochromic and normocytic, but in approximately 25% of the cases may present as hypochromic and/or microcytic.[12] As a result, anemia secondary to these conditions cannot be distinguished from iron deficiency on the basis of the peripheral blood film or RBC indices. In addition, the serum iron concentration is often decreased in these conditions. Measurement of both the serum iron and TIBC may differentiate between the two as the TIBC may be decreased in inflammatory and neoplastic diseases. However, discrimination between normal, iron deficiency, and anemias of chronic disease on the basis of TIBC is poor in many cases. If a bone marrow examination is performed, usually there are increased marrow iron stores. Bone marrow examination may be avoided as serum ferritin concentration will discriminate between iron deficiency (ferritin levels low) vs. anemia of chronic disease in which ferritin levels are increased. In anemias of chronic disease, not uncommonly there may be a combination with iron deficiency. Females with rheumatoid arthritis are a good example of this co-existence. If both factors are present, interpretation of the various laboratory tests may be difficult. A therapeutic approach utilizing a trial of iron therapy can be diagnostic resulting in correction of the anemia if it is due to iron deficiency, partial correction if both factors co-exist or absence of response if the anemia is purely due to the chronic disease.

Normochromic, Normocytic Anemias

When the mean corpuscular volume (MCV) and mean corpuscular hemoglobin concentration (MCHC) are normal, the anemia is normochromic and normocytic. Under these circumstances, the next step from a laboratory point of view in differentiating the cause of the anemia is the reticulocyte count.[13] A reticulocyte count of 3.5% or more in the absence of hematinic therapy is strong evidence of hemorrhage or hemolysis. If the count is 3% or less, the anemia is probably secondary to iron deficiency, chronic diseases, malignancy or bone marrow failure.[14] The most obvious cause of reticulocytosis is acute hemorrhage. Following an episode of hemorrhage, the reticulocytosis reaches a maximum in a week to ten days, subsequently returning to normal over a period of days if there is no further hemorrhaging.

If there is persistent reticulocytosis in the absence of hemorrhage, a hemolytic state has to be ruled out. Most commonly in chronic hemolysis the reticulocyte count varies between 5 and 10%. Two additional laboratory tests have been added recently to the armamentarium aiding in evaluation of the presence of hemolysis. Haptoglobin is an Alpha-2 plasma protein which binds free hemoglobin in a constant ratio forming a haptoglobin-hemoglobin complex which is readily removed by the reticuloendothelial system. This prevents the intravascular accumulation of free hemoglobin in hemolytic anemia and therefore the level of haptoglobin can be a sensitive indicator of intravascular hemolysis. One must keep in mind however that increased haptoglobin levels occur in a variety of disease as it is a "primary reactant" and therefore will become elevated in association with inflammation, infection or neoplasia.[15]

The other feature that has been developed in recent years is that of measuring free hemoglobin in plasma. Two problems have been overcome. The first is learning that the technique of drawing the blood has to be rigidly controlled; if not, artifactual hemolysis can occur in the process as the normal levels of plasma hemoglobin (5 mg./dl.) may be exceeded. Secondly was the finding of a procedure sensitive enough to discriminate normal vs. abnormal at these extremely low levels.[16] One example of hemolytic anemia with normal appearing (non-poikilocytic) RBC morphology is the hemolysis associated with hypersplenism, and although it is often stated that tear-drop poikilocytes are seen with splenomegaly, they usually are not a feature unless the splenomegaly is massive, such as occurs with myelofibrosis.[17]

Glucose-6-phosphate dehydrogenase (G-6PD) deficiency results in hemolysis of an episodic nature related to ingestion of certain drugs or infection. This is actually a heterogeneous group of disease. The so-called A-type[18] is relatively mild, and the most commonly encountered type in the United States affecting approximately 11% of black males and approximately 20% of black females.

Within the past two decades recognition of the relationship between hemolytic disease end deficiencies of G-6PD as well as pyruvate kinase, glucose-phosphate isomerase, and pyrimidine 5'-nucleotidase, has resulted in a clear understanding of hemolytic disease secondary to abnormalities in red blood cell metabolism. These are classified broadly as hereditary non-spherocytic hemolytic anemias. Kits are available (Sigma Chemical Company) which enables routine laboratory analysis for the detection of deficiencies of G-6PD, pyruvate kinase, galactose-1-phosphate uridyl, transferase and glutathione reductase. Of recent interest is the assumption that there is a cause and effect relationship between enzyme deficiency on the one hand and chronic hemolysis on the other with reference to glutathione reductase. Beutler[16] has concluded that partial glutathione reductase deficiency has in itself no hematologic effect and so should probably be classified as a "non-disease."

Normochromic, normocytic anemia in which spherocytosis is seen can indicate either congenital, immune or mechanical disease. A differentiating point is: if the mean corpuscular hemoglobin concentration is increased,[17] the presumption is that congenital spherocytosis is present, as this is not found in acquired spherocytosis.

Macrocytic Anemia

Macrocytosis is present when the mean corpuscular volume (MCV) is 100 um^3 or greater. This along with the morphology of the RBC's on smear are the first step in forming the basis for further steps to establish a precise diagnosis.[21] The three most common causes of macrocytosis are megaloblastic anemia (vitamin B-12 or Folate deficiency), liver disease and reticulocytosis.

Reticulocytosis seldom causes the MCV to exceed 110 um^3 and is usually accompanied by significant polychromia on smear.

The morphological findings of the RBC's on smear in megaloblastic anemia is fairly characteristic, showing macro-ovalocytosis, i.e. large, oval RBC's. In addition to this there generally is significant variation in cell size and shape, and the combination of these findings are important diagnostically in megaloblastic anemia. In addition, in the more severe cases, neutropenia and thrombocytopenia is also present. The presence of neutrophilic hypersegmentation—i.e., neutrophils with five or more lobes may also be present as an early finding.

The widespread availability of serum vitamin B-12 determinations by radioassay along with serum and RBC folate levels can generally differentiate the nature of the deficiency state. Technical problems with all the commercially available B-12 assay kits have recently been identified.[23,22] Of the commercial preparations half contain nonintrinsic factor cobalamin binders which bind and measure analogs of B-12, resulting in falsely elevated values. Measurement of serum folate also involves problems of interpretation in that as many as 45% of hospitalized patients may have low serum folate values.[24] These patients have normal folate levels. These serum levels rapidly increase if the dietary intake of folate is adequate but the folate stores do not.[25] If the RBC folate level is low, reflecting depletion of tissue stores, a true folate deficiency is present. A folate-rich diet or therapy will rapidly affect the serum levels but storage levels increase more slowly, taking at least two weeks. Tissue stores of folate (RBC folate) may also be decreased in vitamin B-12 deficiency, whereas in 25% of cases of pernicious anemia the serum folate is increased.[26,27]

Thus it may be necessary to measure all three parameters, serum vitamin B-12, serum folate and red cell folate (Fig. 3).

The classic two part Schilling test should be performed **after** a deficiency of vitamin B-12 has been

	Serum Vitamin B-12	Serum Folate	RBC Folate
Vitamin B-12 Deficiency	↓	N-↓	↓-N
Folic Acid Deficiency	N-↓	↓	↓
Recently Treated Folic Acid Deficiency*	N	N-↓	↓

Fig. 3. —Vitamin B—12 vs. Serum and RBC Folate levels. (N=Normal, ↑ =increased, ↓ =decreased). *Also hospital diet adequate in folate may result in normal serum folate levels).

demonstrated to differentiate between classic intrinsic factor deficiency (pernicious anemia), which is the most common cause of vitamin B-12 deficiency vs. small bowel disorders such as malabsorption. The problems involved in the Schilling test due to either poor renal function or incomplete urine collection can be avoided by performing a plasma uptake test, measuring the radioactivity of isotope tagged vitamin B-12 in plasma following oral administration of a loading dose.[28] In addition, anti-parietal cell antibodies are positive in approximately 80% of adult patients with pernicious anemia, a reflection of the autoimmune nature of the disease. If anti-intrinsic factor antibodies are present, the diagnosis of pernicious anemia can be made with confidence as these are virtually never present in normal individuals. Asymptomatic elderly patients with atrophic gastritis will have a 10-20% incidence of anti-parietal cell antibodies. Only about one-third of juvenile pernicious anemia patients have detectable parietal cell antibodies, but a 100% incidence of anti-intrinsic factor antibodies.

If a bone marrow examination is to be performed it should be done as early as possible before a Schilling test is performed because the flushing dose will rapidly correct the megaloblastic changes and if the patient is folate deficient due to poor dietary intake, the hospital diet may correct the megaloblastic changes in the marrow. The other conditions associated with macrocytic nonmegaloblastic anemia, such as secondary to liver disease, will then be diagnosed accurately.

Summary

The usefulness of a morphological classification in the approach to a patient with anemia has been enhanced in recent years by the multi parameter instrumentation in the hematology laboratory. Subsequent specific diagnosis has, in many cases, become straightforward due to development or improvement in various laboratory procedures, examples of which are discussed.

References are available from the author upon request.

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Normal Platelet Function

John B. Miale, M.D.

For many years the platelet was considered a rather simple fragment of megakaryocyte cytoplasm, clinically important only when severe thrombocytopenia leads to abnormal bleeding. In recent years, however, we have learned that it is easily the most complex of the circulating blood cells. We know that the platelet undergoes complex reactions and interactions, some of which involve biologic systems other than hemostasis, and that when its hemostatic role malfunctions the result is abnormal bleeding or thromboembolic disease.

An appreciation of how platelets function normally is needed to understand how they can malfunction to cause abnormal bleeding. Furthermore, their role in normal hemostasis can be so exaggerated as to initiate the formation of a thrombus, so that the prevention of thrombosis by the use of drugs that inhibit platelet reactions and interactions is under intensive investigation.

Platelets in normal number and functionally normal are essential to the formation of the "hemostatic plug" responsible for the cessation of bleeding from small blood vessels. The sequence of events leading to the formation of a normal hemostatic plug begins with transection of the vessel wall, leading to the sequence 1) adhesion of platelets to subendothelial tissues, 2) release of platelet constituents (ADP, serotonin, PF3, etc.) and formation of prostaglandin endoperoxides and thromboxane A_2, 3) aggregation of platelets, 4) activation of the coagulation sequence, and 5) deposition of fibrin. The same sequence follows damage or loss of normal endothelium.

If a normal hemostatic plug cannot be formed a subject will bleed when challenged at surgery or will develop ecchymoses after minimal trauma. A normal hemostatic plug cannot be formed if 1) there is thrombocytopenia or 2) the platelets are normal in number but do not function normally.

The relationship of platelet function to normal and abnormal hemostasis has been the subject of numerous articles, monographs and books encompassing clinical, ultrastructural, and biochemical investigations.

Electron microscopy has revealed the ultrastructure of platelets (Fig. 1) and many functions can now be related to submicroscopic structures.[1] The trilaminar cell membrane contains the phospholipid platelet factor 3 (PF3), lipid precursors of prostaglandin endoperoxides, and receptors for the interaction with collagen, thrombin, ADP, epinephrine and the plasma von Willebrand factor.

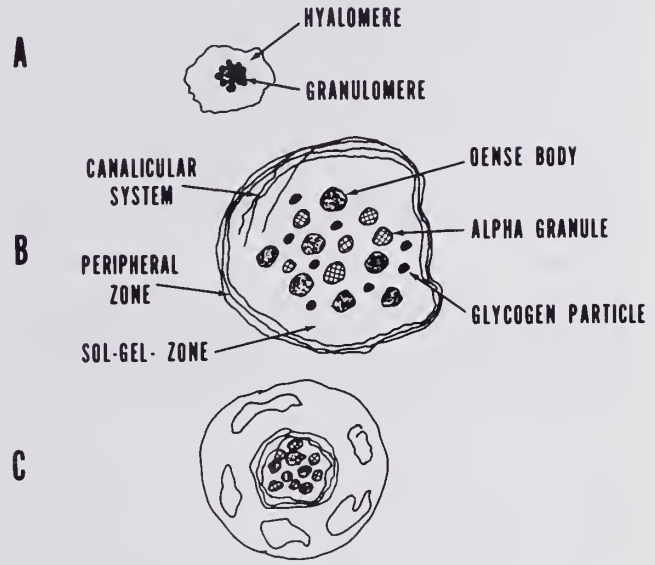


Fig. 1 —Morphology of platelets by light and electron microscopy. A. Morphology by light microscopy; B. Ultrastructure of a normal platelet. C. Ultrastructure of platelet during the release reactions. From Miale, J.B., Laboratory Medicine-Hematology, 5th Edition, 1977, C.V. Mosby Company, St. Louis.



Dr. Miale

The Author

JOHN B. MIALE, M.D.

Dr. Miale took internship and residency training at the University of Rochester Department of Pathology following graduation from the University's Medical School in 1940. From 1944 to 1946, he was Instructor in Pathology at the University of North Carolina Medical School, and Director of Laboratories at Watts Hospital, Durham, N.C. He was then Director of Laboratories at St. Joseph's Hospital and Marshfield Clinic, Marshfield, Wisc., from 1946-1953, and Instructor at the University of Wisconsin Medical School at the same time. Since 1953 he has been Professor of Pathology at the University of Miami School of Medicine, where he was Director of the Clinical Pathology Laboratory 1953-1976, and Acting Chairman of Pathology, 1974-1975. He is now Head of the Section of Experimental Pathology at the University of Miami. Dr. Miale is an international authority in the field of hematology and coagulation and has received numerous awards from national and international organizations. He has published more than 80 papers in the field and is the author of one of the most widely accepted textbooks on hematology in this country.

The cell membrane is traversed by a canalicular system that connects the interior with the outside, providing a route for absorption of plasma constituents into the platelet and for the release of platelet substances into the plasma. Thrombasthenin, the protein responsible for retraction, is located in the submembrane area.

The interior of the cell contains 3 organelles: 1) alpha granules, 2) dense bodies, and 3) mitochondria. The alpha granules are numerous and contain hydrolytic enzymes (acid phosphatase, beta glucuronidase, cathepsin). The dense bodies, so called because they are more electron-dense than the alpha granules, contain serotonin, ADP, ATP, and calcium. Serotonin is absorbed from the plasma and the dense bodies serve as the only storage site. The ADP and ATP in the dense bodies represent a nonmetabolic pool not needed for the metabolism of the cell, whereas the nucleotides not in dense bodies represent the metabolic pool. Mitochondria, glycogen particles and an occasional Golgi body are unimportant remnants of megakaryocytic cytoplasm.

The biochemical regulation of platelet function depends on two interrelated systems, the prostaglandins (Fig. 2) and cyclic AMP (cAMP) (Fig. 3). These diagrams provide the biochemical basis for understanding the pathogenesis of many abnormalities of platelet function.

When platelets are exposed to aggregating agents, they undergo a release reaction[2] in the course of which endogenous platelet substances are released from the granules into the exterior. The dense bodies release ADP, ATP, serotonin, calcium and pyrophosphate. The alpha granules release platelet factor 4 (PF4), beta thromboglobulin, and mitogenic factor. At an ideal concentration of aggregator sufficient ADP is released from normal platelets to participate in the formation of a secondary wave of aggregation. In addition to inducing the primary release reaction, release-inducing agents, especially ADP and collagen, activate a phospholipase that liberates arachidonic acid from phospholipids in the platelet membrane.[3] Arachidonic acid is then converted to cyclic endoperoxides by cyclo-oxygenase and to thromboxane A_2 by thromboxane synthetase. Both the endoperoxides and thromboxane A_2 induce aggregation and the release reactions.[4] Based on current data, it must be concluded that the endoperoxides and thromboxane A_2 act synergistically with the primary aggregation induced by the aggregating agents and that the prostaglandin pathway must be activated for a secondary wave of aggregation and a full release reaction.[5]

Until recently, there was no known physiologic inhibitor for the release reactions of platelets induced by thromboxane A_2 at the site of endothelial injury. However, investigators have found that a microsomal enzyme, prostacyclin synthetase, converts prostaglandin endoperoxides or thromboxane A_2 to prostacyclin

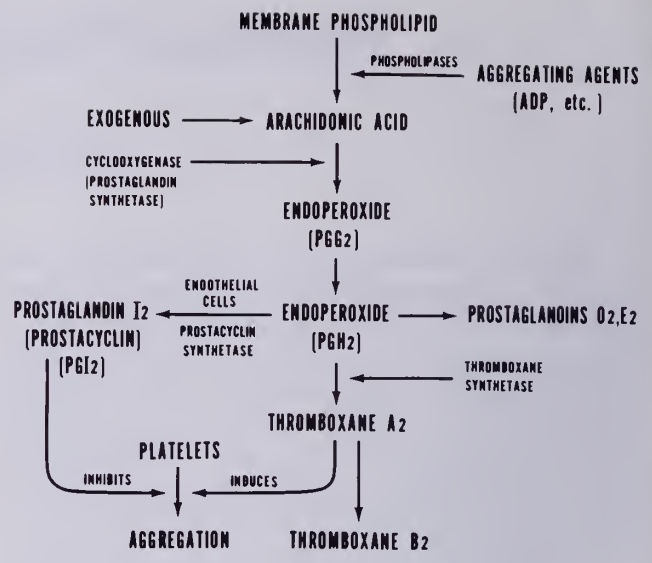


Fig. 2. —Metabolism of arachidonic acid in platelets.

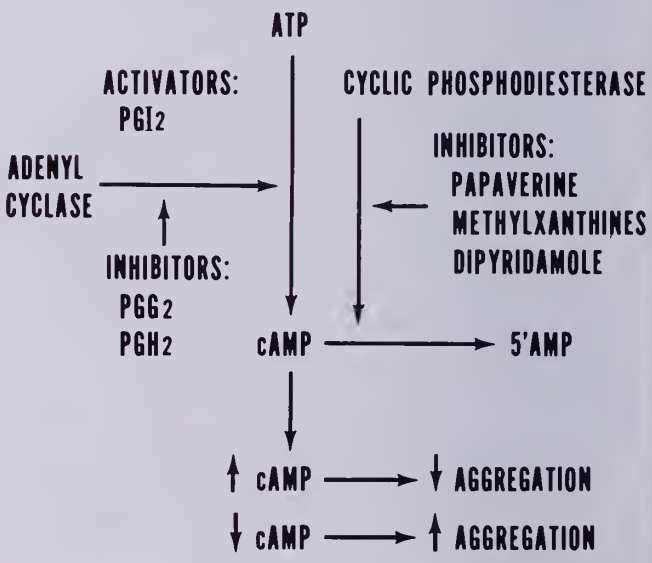


Fig. 3. —Interrelation of prostaglandins and cAMP in platelet reactions.

(PGI_2), a potent inhibitor of aggregation. Prostacyclin synthetase is found in many organs but it is postulated that it is that in the vessel wall which is responsible for the local synthesis of PGI_2 that counteracts the aggregation of platelets at the damaged subendothelial site. Should there be a lesion in the arterial wall, for example an atheroma, it is assumed that the local synthesis of PGI_2 is retarded and that the uninhibited action of thromboxane A_2 favors thrombosis at that site.

Aspirin and indomethacin inhibit cyclo-oxygenase and thus block the formation of endoperoxides and thromboxane A_2.[6] Theoretically, the ingestion of aspirin or other drugs that inhibit the biochemical reactions responsible for platelet aggregation should be useful in the prophylaxis of thromboembolic disease. In fact, a number of clinical trials are in progress to determine whether aspirin or other drugs do inhibit thrombosis.

The prostaglandin system is also involved in regulating the level of cAMP (Fig. 3). As shown, the level of cAMP is controlled by a balance between oppositely acting prostaglandins as well as by drugs that act either directly on the formation or catabolism of cAMP, for example, Persantin (dipyridamole) which inhibits cyclic phosphodiesterase, or indirectly by their action on prostaglandin metabolism, for example, aspirin and other non-steroid anti-inflammatory drugs. When the summation of effects is an increase in cell cAMP there is reluctance for platelets to aggregate, whereas a decrease in cAMP favors platelet aggregation.

There is, at this time, no firm basis for determining the relative importance of the two biochemical systems. It is fair to say that a primary aggregation-inducing and release-inducing agent, particularly collagen, acts synergistically with the formation of thromboxane A_2 and that the effect is inhibited by the formation of PGI_2.

There is one other link between platelets and thrombosis. Among the platelet constituents released during the release reaction is a "growth factor" or "mitogenic factor" that stimulates proliferation of smooth muscle cells in the subintimal zone of an artery.[7] The subintimal thickening probably predisposes to the development of an atherosclerotic lesion. For example, thrombocytopenic rabbits do not develop atherosclerosis.[8] Also, pigs having the classic von Willebrand's disease develop little or no arteriosclerosis as compared to normal pigs.[9]

References are available from the author upon request.

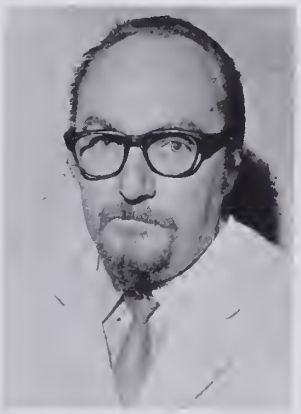
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Platelet Function Studies: Clinical Applications

Kenneth N. McCormick, M.D.

Abstract: Hemostasis is maintained by four systems: vascular, plasma clotting factors, platelets, and fibrinolysis. The role of platelets in hemostasis with laboratory procedures to determine their functional state are described. Platelet aggregation studies are stressed.

The maintenance of human life depends on the ready availability of nutrients and oxygen to the tissues and the continuous removal of wastes from these same tissues. This constant supply of nutrients to and the elimination of metabolites from the tissues is in turn dependent on the maintenance of an intact vascular system with its circulating liquid blood. Blocking the flow of blood, as in thrombosis, or the loss of the fluid from the vascular space, as in hemorrhage, have similar effects, i.e., tissue death. Hemostasis is the process by which the blood is maintained in the liquid state within the intact intravascular space. Four related systems are involved in hemostasis: 1) Functional platelets in adequate number, 2) Intact vasculature, 3) Plasma clotting factors, 4) The often overlooked fibrinolytic system. We will focus our



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attention to the contribution of platelets, but without the ever present interplay of all four components of hemostasis, an event as minor as a mosquito bite would result in a life threatening hemorrhage or massive intravascular thrombosis.

When evaluating a patient for a hemorrhagic disorder we must consider the possiblity of a defect in any of the above four areas. As a part of the screening process, I cannot overstress the importance of an adequate patient history. Laboratory tests are of minimal significance when compared with the patient's own description of his problem. Patients with platelet disorders most often give a history of mucous membrane bleeding (menorrhagia, epistaxis), purpura, and petechiae. It can be debated that a reliable patient with a negative history precludes the need for any platelet studies whatsoever. We consider laboratory procedures to merely complement the history. Indeed, patients with vascular disorders often exhibit no abnormal laboratory studies.

We are presently concerned about the platelet's role in hemostasis. Fig. 1 is a general guide for determining which patients require platelet studies. The reader may refer to any of the excellent treatises available for further elaboration of hemostatic problems due to factors other than platelets.[1] Any hospital, large or small, should consider, as a screen for platelet abnormalities, three basic procedures: 1) Platelet count, 2) Clot retraction, 3) Bleeding time. If abnormal or equivocal results are obtained, further testing should be considered. Platelet retention and aggregation studies will be helpful in such situations. We will briefly discuss each of these procedures with particular attention being given to aggregation studies. We have found the simple-to-perform tourniquet test to be too often falsely positive and the Lee-White clot time to be too often falsely normal to be of much help.

Platelet Count

The platelets can be directly quantitated by phase contrast or the Rees-Ecker method. Automation has largely replaced these manual methods. Both elevated and depressed platelet counts can eventuate in hemorrhagic problems. With functioning platelets, thrombocytopenia seldom is associated with spontaneous hemorrhage unless the count falls below 25,000/mm^3. Extremely elevated platelet counts (over 1,000,000/mm^3) are related to either or both thrombosis or hemorrhage. Platelet counts should be substantiated with a blood smear evaluation.

Clot Retraction

This measures the ability of platelets to contract. The test can utilize whole blood or plasma and can be qualitative or quantitative. Although clot retraction does not correlate well with the platelet count, intact functional platelets are required for clot retraction. Clot retraction occurs within one hour and may be reported as positive or negative, or as a percentage of plasma.

Bleeding Time

The modified method of Ivy using a standardized disposable template device is recommended since it is the most reproducible method. A sphygmomanometer is put on the patient's upper arm and the pressure is maintained at 40 mm. of mercury. The template is applied with minimal pressure on the volar surface of the forearm in an area devoid of visible veins. The incision is made and

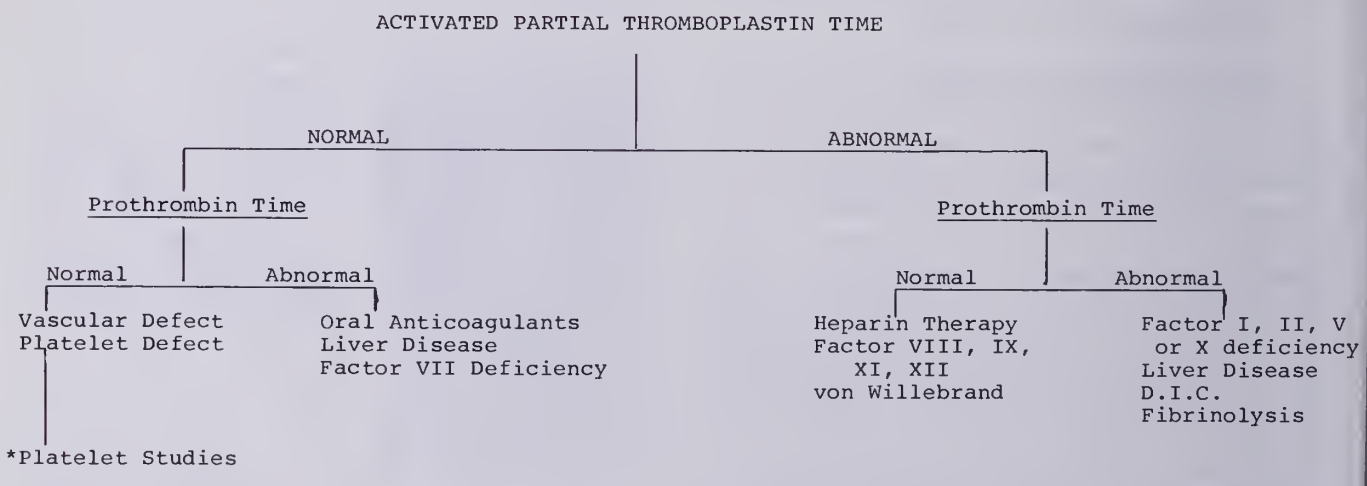


Fig. 1 - Indications for Platelet Studies

the blood is blotted every thirty seconds until the flow ceases. Normal values range between one and seven minutes. We find that patients best accept this test if they are briefly told about the procedure and afterwards have the wound closed with a butterfly. The procedure is an excellent one for it estimates platelet function and, to some extent, vascular integrity.

Platelet Adhesiveness or Retention

When blood vessels are disrupted, the platelets are exposed to tissue substances including collagen which cause them to adhere to the cut tissues. Platelets behave similarly when exposed to glass beads. Non-functioning platelets do not adhere to these materials. Two reliable methods of estimating platelet adhesion are available: the in vivo and the in vitro methods. In the former method an incision is made similar to that in the bleeding time procedure. Platelet counts are performed on the blood issuing from this wound and are compared to a venous platelet count. The in vitro method utilizes a commercially available standardized tube containing glass beads. A venous sample is injected into this tube of beads via a standardized pump. The platelet count is performed on the blood after it has passed through the beads, and this count is compared with the patient's routinely obtained platelet count. Results are expressed as a percentage, normal values ranging between 25-60% retention. Values vary somewhat between laboratories.

Platelet Aggregation

Platelets can be stimulated by various agents to adhere or stick to each other to form platelet clumps. Fibrinogen and small amounts of ionized calcium are required for this to occur. Physiologically, subendothelial collagen and tissue ADP induce platelets to aggregate to form platelet clumps which in turn plug the injured small blood vessels.[2] The platelets eventually are incorporated into the clot and even into the endothelium itself. During

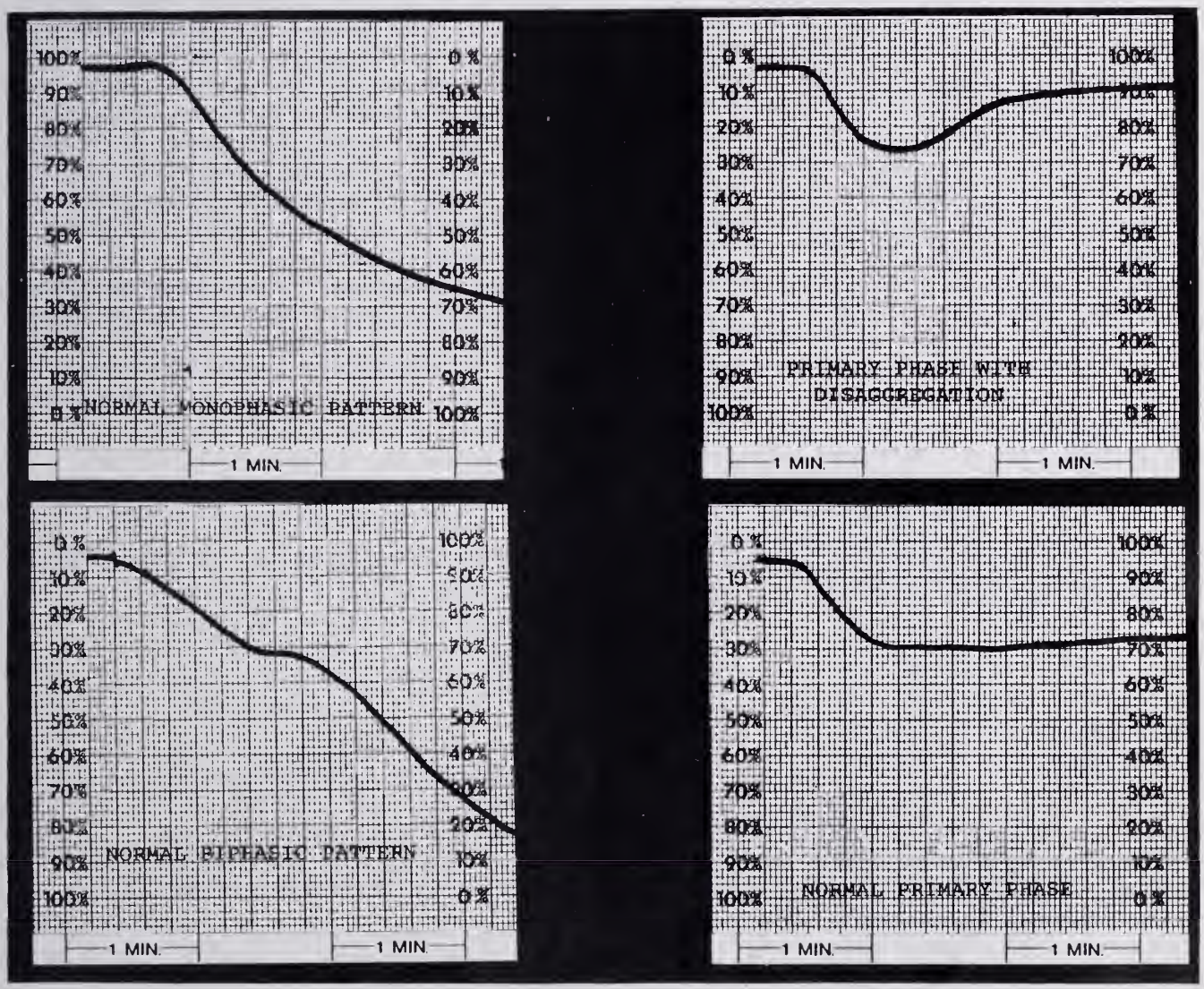


Fig. 2. —Platelets aggregation patterns

the aggregation process platelets release a phospholipid (platelet factor III) as well as large amounts of ADP. The released platelet factor III plays a vital role in the intrinsic coagulation scheme, and the released endogenous platelet ADP causes further and irreversible platelet aggregation.[3]

In the laboratory platelet aggregation studies are performed utilizing a commercially available modified photometer called an aggregometer. The patient's blood is centrifuged at low speed and the erythrocyte-free platelet rich plasma is removed to a cuvette. The patient's blood is then returned to the centrifuge and processed at high speed. The platelet poor plasma is then decanted into a second cuvette. This platelet-poor plasma is, in effect, a patient blank which the aggregometer automatically compensates for plasma turbidity or icterus. The aggregation inducing drug is then added to the patient's plasma and the change in light transmission is measured on a graph (Fig. 2). The normal patterns of platelet aggregation vary with the different aggregating agents used as well as their concentrations. Low concentrations of ADP cause a primary wave which is due to the direct aggregating properties of the added or exogenous ADP. The low concentration of the added ADP is insufficient to cause the release of endogenous or platelet-contained ADP, so no further aggregation occurs. With higher concentrations of ADP both the primary aggregation (caused by the exogenous ADP) and secondary aggregation (caused by the platelets releasing their endogenous ADP) waves are observed. Epinephrine induces aggregation patterns similar to ADP but is so temperature sensitive that up to 50% of normal patients will have abnormal epinephrine patterns. Collagen gives a monophasic pattern because its induction of aggregation depends solely on the release by the platelets of endogenous ADP. Aggregation by collagen occurs after a lag period, whereas aggregation induced by ADP is almost immediate. The antibiotic ristocetin induces a biphasic pattern. Ristocetin patterns are abnormal in von Willebrand's syndrome, as well as in several other disease states such as infectious mononucleosis. Normal plasma will correct the abnormal ristocetin aggregation pattern in von Willebrand's syndrome, and patients with von Willebrand's syndrome show normal aggregation with collagen and ADP. It must be stressed that patients should abstain from all medication for the ten days prior to platelet aggregation studies since drugs, especially aspirin containing agents, decrease the ADP stores in platelets for their entire lifetime of ten days.

Platelet aggregation can be reported in a quantitative manner, but we prefer a simpler and, I believe, more informative means of reporting by forwarding a copy of the actual aggregation curve to the clinician with our comments.

Conclusion

Platelet function studies can be performed by all hospital laboratories. We have stressed the detection of platelet abnormalities by patient history and laboratory studies, and have deliberately not stressed the precise diagnoses in these patients. When elective surgery is contemplated, the detection of a platelet disorder will alert the physician to obtain proper hematologic consultation. Patients with hereditary thrombocytic disorders can then undergo their surgery with platelet transfusions available before the initial incision. Patients with acquired platelet abnormalities can be treated with drugs (or the removal of drugs such as aspirin) and, if indicated, platelet transfusions.

No one really knows how many problems such as seromas, wound infections, dehiscences, and blatant hemorrhage may be eliminated when the platelet disorders are detected and treated. Perhaps even an occasional menorrhagic patient may be enabled to keep her uterus.

References are available upon request from the author.

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Thrombasthenia and Thrombocytopathy: Sick and Tired Platelets

John B. Miale, M.D.

The oldest term used to describe a functional platelet abnormality is "thrombasthenia," proposed by Glanzmann in 1918[1]. By present standards, however, the cases he described did not make up a homogeneous group, and the term *thrombasthenia*, without the eponym, can now be defined more precisely.[2]

The second type of functional platelet abnormality, called *thrombocytopathy*, is more common. It is made up of a number of subtypes distinguished by the pathogenesis of the defect and the laboratory studies that identify the defect. Classification on the basis of pathogenesis is based on what is known about normal platelet function.[3]

Except as noted, the platelet count is normal in the functional platelet abnormalities. The bleeding time is prolonged, and in fact it is the finding of a normal platelet count and prolonged bleeding time in the presence of normal coagulation studies that requires a study of platelet function. Clinically, there is usually evidence of abnormal hemostasis, most commonly ecchymoses. Nosebleeds, menorrhagia, and bleeding at surgery may be severe.

The classification of functional platelet abnormalities is undergoing continuous revision as new information becomes available. The classification presented here is the one currently in use in my laboratory.

I. Thrombasthenia. Autosomal recessive trait.

   A. Pathogenesis: Failure of primary aggregation, probably a deficiency of membrane glycolipid receptors for aggregating agents.[4,5] A deficiency of thrombasthenin is also reported.[6]

   B. Laboratory Findings: 1) absent or poor clot retraction (the only platelet dysfunction exhibiting this abnormality), 2) normal platelet count, 3) prolonged bleeding time, 4) very weak or absent aggregation with ADP, collagen, epinephrine, thrombin, or ristocetin, 6) normal plasma factor VIII procoagulant and antigen.

II. Thrombocytopathies. The pathogenesis of thrombocytopathy is varied and the classification presented here is based on the nature of the biochemical or functional defect.

   A. Bernard-Soulier Syndrome.[7]

      1. Pathogenesis. An autosomal recessive trait. Probable abnormality is a membrane defect so that the platelets cannot bind factors V, XI, or VIII. Failure to bind factors V and XI [8] accounts for an abnormally short prothrombin consumption time[9] but by the kaolin-activation method PF3 availability is normal.[10] The membrane also fails to bind factor VIII so that there is no aggregation by ristocetin or bovine factor VIII. The membrane defect may be a lack of glycoprotein necessary for full expression of binding sites.[11]

      2. Laboratory findings: 1) moderate thrombocytopenia, 2) many abnormal "giant" platelets, 3) prolonged bleeding time, 4) normal clot retraction, 5) normal aggregation by ADP, epinephrine, collagen, or thrombin, 6) no aggregation by ristocetin, 7) normal plasma factor VIII procoagulant and antigen.

   B. Storage Pool Disease.[12,13]

      1. Pathogenesis. This defect is characterized by diminished release of non-metabolic nucleotides, especially ADP, from the dense bodies. It is usually classified into two subtypes. In the first there is a

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deficiency of nucleotides in the dense bodies which are few in number[14] so that the calcium and serotonin content is also low.[15] Synthesis of endoperoxides and of thromboxane A_2 is normal but the release reaction is faulty.[16] In the second type, the nucleotide content of the dense bodies is normal but the release mechanism is faulty. This resembles the effect of aspirin, and in fact the second category is commonly called an "aspirin-like" defect. I doubt whether this is completely acceptable, for various reasons. The defect induced by aspirin is inhibition of cyclo-oxygenase and prostaglandin synthesis, whereas in the second category of storage pool disease there is no good evidence implicating blockage of cyclo-oxygenase or prostaglandin synthesis. Also, some cases have shown defective PF3 release and abnormal platelet adhesiveness, not seen in the aspirin lesion.[17] The pathogenesis of storage pool disease is probably complex and requires further clarification.

Storage pool disease may be familial or idiopathic. Acquired forms are reported in disseminated lupus erythematosus and other autoimmune diseases.[18] Storage pool disease has been described in a number of congenital syndromes: Hermansky-Pudlak,[19] Wiskott-Aldrich[20] and thrombocytopenia with absent radii.[21]

2. Laboratory findings: 1) bleeding time prolonged, 2) platelet count normal, 3) defective platelet adhesiveness, 4) normal clot retraction, 5) normal primary wave aggregation with ADP but absent secondary wave, defective aggregation with collagen and thrombin, small primary wave with epinephrine and absent secondary wave, 6) normal factor VIII procoagulant and antigen. Special features: in the Wiskott-Aldrich syndrome there is moderate thrombocytopenia and the platelets are smaller than normal.

C. Failure to synthesize prostaglandins.

1. Pathogenesis: A congenital or acquired deficiency of any enzymes involved in prostaglandin synthesis causes a failure in the production of prostaglandins involved in platelet reactions. Cyclo-oxygenase deficiency may be congenital [22,23] or acquired following ingestion of aspirin, phenylbutazone, indomethacin, colchicine, imipramine HC1, or vinblastine.[24] Inhibition of prostaglandin synthesis, but at different sites, can result from deficiency of thromboxane synthetase or phospholipase.

2. Laboratory findings: essentially the same as for storage pool disease, since the net effect in both is a defective release reaction. In cyclo-oxygenase deficiency, congenital or acquired, platelets are not aggregated by sodium arachidonate but are aggregated by thromboxane A_2 or endoperoxides.[23]

D. Deficient plasmatic cofactors.

1. Fibrinogen.

a. Pathogenesis. Fibrinogen was the first plasmatic cofactor found to be required for normal platelet function.[25,26] Fibrinogen is required for adhesion and aggregation reactions in vitro, but the reason for the fibrinogen requirement for normal in vivo reactions is still conjectural. It is suggested that membrane-bound fibrinogen, probably the carboxyterminal part of the alpha chain, is required for normal aggregation with ADP, collagen and thrombin.[27]

b. Laboratory findings: 1) strikingly prolonged coagulation tests (L.W.C.T., P.T., A.P.T.T., T.T.) should suggest the diagnosis, confirmed by quantifying plasma fibrinogen, and a study of platelet

function is academic, 2) normal platelet count, 3) prolonged bleeding time, 4) decreased adhesiveness to glass beads, 5) defective ADP and epinephrine aggregation of platelets in citrated plasma, normal in heparinized plasma, 6) diminished PF3 availability, 7) all abnormalities corrected by the addition of fibrinogen.

2. Von Willebrand factor.

a. Pathogenesis. In the classic von Willebrand's disease there is a lack of a component of the normal factor VIII molecule. This component, the von Willebrand factor (VIII-RWF), interacts with a specific receptor on the platelet membrane following which platelets are aggregated by ristocetin.[28] In the absence of VIII-RWF there is clinical bleeding, abnormal platelet adhesiveness in vivo[29] and in vitro[30] and a prolonged bleeding time.[31] It is generally agreed that the apparent thrombocytopathy is not the result of an intrinsic platelet defect but rather that platelets need to interact with VIII-RWF in order to function normally. This view is supported by the observations that, 1) addition of a factor VIII-containing plasma fraction corrects the defective in vitro adhesiveness[30] and 2) correction by factor VIII can be inhibited by anti-VIII antiserum.[32] It is also noteworthy that von Willebrand platelets adhere poorly to the subendothelium of rabbit aortas.[33]

Variants of the classic disease are common[34] and not only present diagnostic difficulties but raise questions of pathogenesis. Almost every combination of the findings in classic von Willebrand's disease has been described.

b. Laboratory findings. 1) normal platelet count, 2) normal clot retraction, 3) prolonged bleeding time, 4) decreased platelet adhesiveness in vitro and in vivo, 5) decreased factor VIII procoagulant (VIII:C) 6) decreased or absent factor VIII antigen (VIII-R:AG), 7) decreased ristocetin cofactor (VIII:RWF), 8) hyperresponse of VIII:C to transfusion, 9) normal aggregation with ADP, epinephrine, collagen and thrombin, and 10) failure of aggregation by ristocetin.

The variants show various combinations of the above, but we find that none show absent ristocetin aggregation, that very few have a reduction of VIII:C, and that the assays of VIII-R:AG and VIII:RWF vary from moderately low to normal.

3. Deficiency of coagulation factors.

Many of the coagulation factors may be needed for normal platelet function. Using an antiserum against human factors II, VII, IX and X we have shown that when added to PRP platelet aggregation is inhibited.[35] We have not found abnormal aggregation in several cases of factor XI deficiency.

4. Calcium chelators.
Complete removal of ionized calcium by chelators such as EDTA inhibits adhesiveness and aggregation. Interference with platelet reactions will be found if the concentration of citrate is too high,[30,36]

E. Stimulators of cAMP System.[3]
cAMP probably acts synergistically with ADP and the prostaglandins to regulate platelet function, but the relative importance of each is not determined. cAMP is derived from ATP by the action of adenyl cyclase. Activators of adenyl cyclase (PGI_2), adenosine increase the level of cAMP and inhibit platelet aggregation. Inhibitors of adenyl cyclase decrease cAMP and favor aggregation. cAMP is converted to inactive 5'AMP by phosphodiesterase so that inhibitors of phosphodiesterase (persantin, caffeine, theophyl-

line, aminophylline, papaverine) increase cAMP and inhibit aggregation.

Persantin (dipyridamole) is used clinically to inhibit in vivo platelet aggregation. The effect is the same as that from ingestion of aspirin, inhibition of secondary wave aggregation.

F. Defective Nucleotide metabolism
In glycogen storage disease, type I,[37] and in glucose-6-phosphate dehydrogenase deficiency, B-negative type, the defect resembles a mild release abnormality.[38]

G. Defective adhesion to subendothelial tissues. There are several reports of platelet malfunction caused by abnormal interaction with subendothelial tissues (collagen).[39-41] The abnormality may be idiopathic or in association with hereditary disease of connective tissue such as in the Ehlers-Danlos syndrome.[42] In the one case studied in my laboratory, there was abnormal platelet adhesiveness by the in vivo method of Borchgrevink but normal retention on a glass bead column.

H. Platelet Factor 3 Deficiency
Many of the thrombocytopathies due to an abnormal release reaction will show a failure to release PF3, along with other platelet constituents. An isolated deficiency of PF3 has been described[43] and in another case the deficiency of PF3 was associated with a deficiency of glucose-6-phosphate dehydrogenase.[38]

I. Pathogenesis Not Defined.
Various functional platelet abnormalities, varying in severity from very mild to moderate, have been found in association with many disease states. Not only is it difficult to determine how much the platelet dysfunction contributes to the hemostatic defects in these cases, but also it is not possible at this time to define what biochemical or structural abnormality is responsible for the platelet dysfunction.

The following is a partial list of the more common diseases in which platelet dysfunction has been described:

1. Myeloproliferative disorders
2. Renal failure
3. Macroglobulinemia
4. Multiple myeloma
5. Various drugs
6. Cyanotic heart disease
7. Cirrhosis of the liver
8. Scurvy
9. Pernicious anemia

References are available from the author upon request.

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A Pathologist's View of The Bone Marrow

Arkadi M. Rywlin, M.D.

Until recent years the bone marrow has been the stepchild of pathologists. It is the only organ in the body that has been studied more extensively by cytology than histology. There are several reasons for this. Bone marrow obtained at autopsy is modified by autolysis, decalcification, sawing or squeezing artifacts making it difficult to recognize the cytologic details seen so beautifully in well prepared smears of in-vivo obtained material stained with the Giemsa Wright method. With the introduction of massive chemotherapy, patients with hematologic disorders who come to autopsy often have a completely wiped out marrow, the study of which contributes little to the understanding of the underlying disease.

Bone marrow histology of specimens obtained in-vivo has also been neglected in the past. Bone marrow examinations were performed by clinical hematologists or clinical pathologists who had little training in histologic techniques. The techniques available for obtaining bone marrow for histologic examinations were complex and cumbersome. In the view of many hematologists bone marrow histology was not adding any significant information to that obtained from the study of smears. Bone marrow pathology is rarely discussed in slide seminars in part because it is difficult to obtain the many slides needed for such an exercise from the relatively scanty aspirated or biopsied material.

Today the usefulness of bone marrow histology in addition to the study of smears is generally recognized. To omit a histological evaluation of the bone marrow is poor medical practice.

There is no general agreement as to the preferred technique for securing bone marrow for histologic examination. Bone marrow can be obtained for histologic examination by aspiration, needle biopsy or surgical biopsy. Surgical biopsy is rarely, if ever, necessary for the diagnosis of a hematologic disorder.

The quality of the histologic preparations obtained by bone marrow aspiration varies with the amount of marrow aspirated and with the processing technique. Two general techniques are available: 1) the clot section and 2) concentration of particles. The clot section, perhaps the most commonly used technique, is totally inadequate and should be abandoned. It yields a few particles immersed in a sea of clotted blood. Concentration of particles can be achieved in various ways: picking up individual particles, centrifugation of anticoagulated marrow or filtration of the aspirated marrow. I prefer the filtration technique because of its simplicity.[1] We routinely aspirate 10 ml of a mixture of marrow and peripheral blood. Most of the aspirated material is immediately ejected into a neutral buffered 10% formalin solution. The remaining drops of the marrow are used for preparing smears. The bone marrow formalin mixture is filtered through a special paper to concentrate the particles (HISTO-WRAP, Obex Industries, Inc. Amherst, New York). The particles aggregated on the filter paper are washed with a squeeze bottle containing the buffered neutral formalin until most of the peripheral blood has been filtered. The aggregated particles are then processed through the Autotechnicon. This method yields an excellent preparation (Fig. 1). To obtain many particles in the aspirate it is advisable to wiggle the bone marrow needle once the desired depth of penetration has been achieved. This wiggling dislodges bone marrow particles which are readily aspirated.



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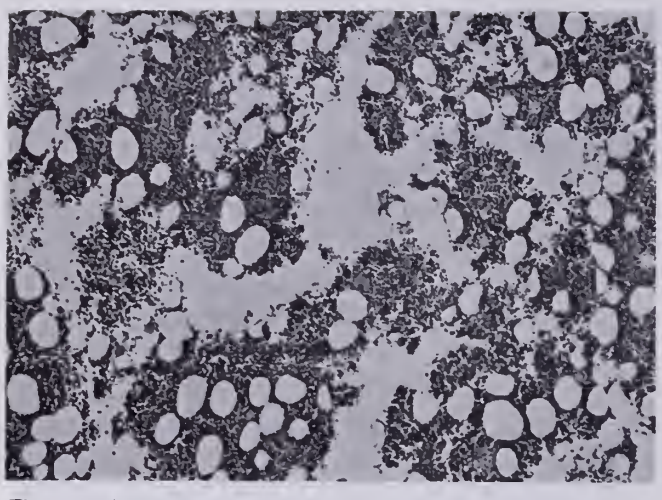


Fig. 1. — Appearance of sectioned concentrated bone marrow particles. H&E, low power.

Another method for obtaining bone marrow for histologic examination is the needle biopsy. The needle most commonly used in this country is the Jamshidi needle.[2] Recently Block[3] has recommended that the biopsied bone and marrow be embedded in methacrylate rather than paraplast. Better cytologic detail can be obtained in methacrylate embedded tissue and it may be useful in instances of a "dry tap" when no imprints or smears are available. In Europe larger trocars are used. They require a skin incision and yield good preparations.[4,5] The Bordier[6,7] trocar is best for the study of metabolic bone disease. It gives a good core of bone and marrow. For quantitative data in the study of metabolic bone disease undecalcified tissue has to be embedded in methacrylate. If tetracycline has been given to the patient it is possible to evaluate the rate of osteoid formation.

Though there is general agreement today that a complete bone marrow examination must include histology in addition to cytology, there is controversy whether the method of choice is aspiration or biopsy.[8,10] Ioannides and I have addressed this problem by aspirating and coring the marrow in 30 cadavers.[11] Techniques identical with those used in living patients were employed. Ten ml. of bone marrow were aspirated with a 16-gauge Osgood needle in one posterior superior iliac spine and a needle biopsy was performed in the opposite iliac spine. Half the cases were biopsied with a 14-gauge Franklin-Silverman needle and half with an 11-gauge Jamshidi needle. The obtained specimens were weighed and a morphometric point counting technique was used to evaluate the surface area of bone marrow available for histologic examination. More marrow was secured and larger areas of marrow were seen in aspirated than in cored specimens. Biopsy by the Jamshidi needle was superior to the Franklin-Silverman needle. Block[3] criticized our study because it was performed on cadavers. He stated that "aspiration of 10 ml of marrow may be possible from cadavers, but is rarely possible in-vivo; in a cadaver, the blood is usually congealed or clotted and so is less likely to dilute the aspirated marrow." Actually it is much easier to aspirate 10 ml from a living patient than from a cadaver. I have always said that the aspirated material is a mixture of blood and marrow and that the marrow particles are concentrated by filtration. Working with cadavers favors the coring technique because one advances the coring needle with less apprehension and aspiration is more difficult.

In addition to yielding more marrow for examination, the aspiration procedure was superior to the core biopsy in the following aspects: 1) Cytologic details were sharper in histologic sections of aspirates. 2) Giemsa and Leder stains were far better in aspirates than in decalcified biopsies. 3) Evaluation of hemosiderin stores is more accurate in aspirated material because the leaching of iron by acid decalcifying solutions is avoided. Also decalcification with some products may interfere with the demonstration of acid fast organisms in granulomatous diseases.[12] 4) Aspirates are more likely to reveal lymphoid nodules, granulomas, metastatic carcinoma and vascular lesions. This is because more marrow is seen by aspiration than by core biopsy. 5) Obtaining marrow by aspiration yields material for histologic sections and smears with one procedure. If marrow is obtained by core biopsy the needle has to be replaced for aspiration so that material can be secured for smears. 6) Aspiration can be performed in the sternum and other sites which are not suitable for biopsy. 7) Aspiration can be carried out in the presence of thrombocytopenia and other coagulopathies. 8) In my experience, which is contrary to Block's,[3] the amount of discomfort experienced by the patient during aspiration or biopsy is about the same. The following day, however, the biopsy site is usually more tender than the aspirated site.

A core biopsy must be obtained if aspiration results in a "dry tap." Furthermore the core biopsy permits the recognition of a paratrabecular location of lymphoid infiltrates which may help to decide whether they are benign or malignant. Bone pathology can only be examined in biopsies.

Authors who have found core biopsy more effective than histologic sections prepared from aspirates have utilized the "clot section" and do not state how much marrow was aspirated.[10,13] I certainly agree that the clot section is unsatisfactory and should be abandoned.

The technique used for obtaining marrow is less important than the recognition that histologic examination of the marrow in addition to the cytologic study is an absolute must.

Histologic examination of the bone marrow contributes greatly to our understanding of hematologic

disorders. It is also invaluable in the diagnosis of granulomatous, vascular and bone diseases.

Space does not permit a thorough discussion of the contribution of bone marrow histology to the evaluation of hematologic disorders. Certainly bone marrow cellularity is more accurately evaluated in histologic sections than in smears. Hemosiderin stores are best evaluated in histologic sections of aspirated marrow. Extensive myelofibrosis whether of the reticulin or collagen type can only be studied in histologic sections.[1] The accurate staging of malignant lymphomas requires the study of bone marrow sections. Comparative studies of smears and sections have shown that many nodular lymphoid infiltrates cannot be recognized in smears.[14] Also a perfectly normal smeared out lymphoid nodule may mimic chronic lympho-cytic leukemia. Histologic sections are superior to smears in the diagnosis of early cases of multiple myeloma.[15] Only in sections can the neoplastic nature of some cytologically benign appearing plasma cells be recognized by their tendency to replace fatty and hematopoietic marrow. Necrosis of the marrow,[16,17] amyloidosis[1] and metastatic tumor cells[1] are far easier to diagnose in section than in smears.

Bone marrow findings have been described in angioimmunoblastic lymphadenopathy.[18] They were usually focal, occasionally confluent. They consisted of fibroblast-like, spindle-shaped nuclei admixed with lymphocytes, plasma cells and large pyroninophilic cells. Eosinophils were prominent in some cases.[18]

The study of bone marrow sections extends the diagnostic potential of bone marrow examinations beyond the field of hematology. Bone marrow aspiration is safer, simpler and less expensive than skin, muscle and liver biopsies which are often performed as diagnostic procedures in patients suffering from fever of unknown origin or suspected of harboring a collagen disease.

Granulomatous diseases can be easily diagnosed from bone marrow sections. Certainly it would be useful to study the bone marrow with newer aspiration and biopsy techniques in cases of sarcoidosis to determine the frequency of bone marrow involvement. Indeed Burkhardt[4] has stated that in his experience with sarcoidosis the marrow is more frequently involved than the liver. It is important not to confuse sarcoid granulomas with lipid granulomas which may exhibit a sarcoid evolution (Fig. 2). The lipid granuloma is the most frequently encountered granuloma in the bone marrow.[19]

The bone marrow is often involved in lepromatous leprosy.[20] Sometimes collections of striking Virchow cells with globi can be seen (Fig. 3). However, we have noted that even when no bacilli-containing histiocytes are demonstrable with hematoxylin and eosin and Giemsa, a Fite stain may show acid-fast organisms in histiocytes, endothelial cells and lying free in the tissue.[21]

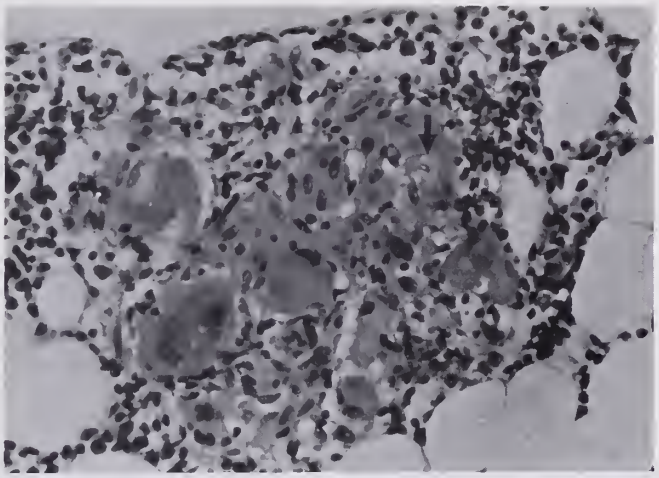


Fig. 2. — Sarcoid appearance of lipid granuloma. Note asteroid body (arrow). H&E, high dry power.

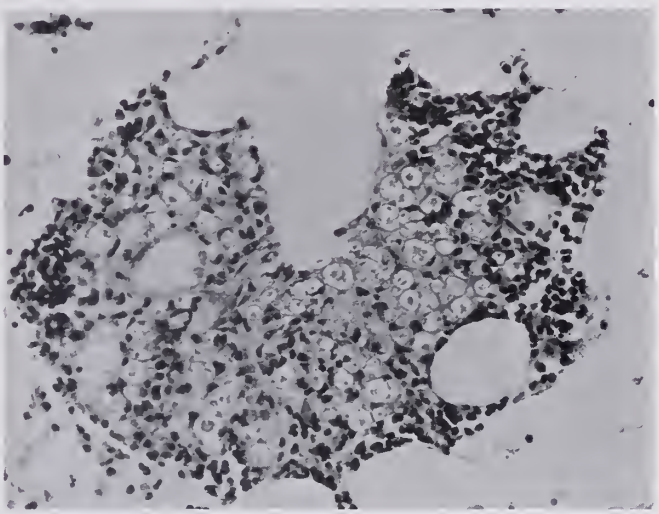


Fig. 3. — Numerous histocytes containing globi of mycobacterium leprae (Virchow cells). H&E, high dry power.

Lesions in the bone marrow can be found in other infectious diseases including Q-fever in which "doughnut type" granulomas have been described.[22,23] These are not specific for Q-fever in my experience.

Granulomatous lesions can also be seen in the bone marrow in association with drug reactions.[24] Whether the eosinophilic fibrohistiocytic lesion (Fig. 4) which appears to be made up of mast cells is related to drugs or represents a peculiar form of mast cells disease remains to be seen.[25,27]

Vascular disease can often be diagnosed on sections of aspirated or cored bone marrow. I have illustrated the findings in thrombotic thrombocytopenic purpura and polyarteritis nodosa.[1] Cholesterol emboli can be easily diagnosed in bone marrow sections (Fig. 5). Widespread cholesterol emboli may present clinically as a multisys-

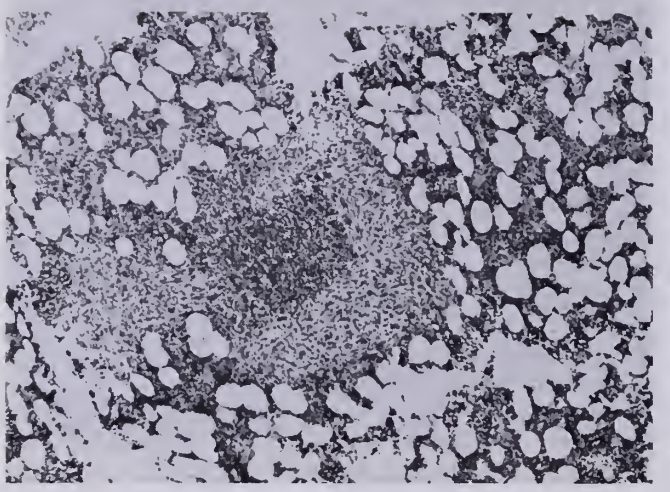


Fig. 4. — Eosinophilic fibrohistiocytic lesion surrounding a lymphoid nodule. Eosinophils cannot be recognized in this photograph. It is possible that the "fibrohistiocytes" represent degranulated mast cells. H&E, low power.

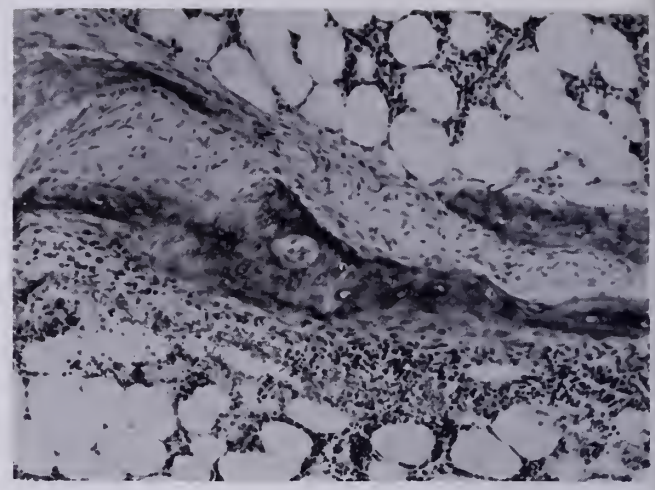


Fig. 6. — Hyperparathyroidism. Note metaplastic bone formation and endosteal fibrosis. H&E, medium power.

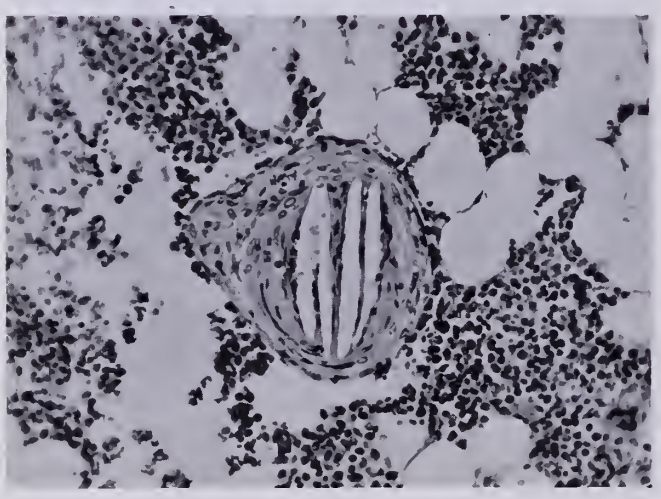


Fig. 5. — Bone marrow arteriole with cholesterol emboli. H&E, high dry power.

tem illness with neurologic abnormalities, retinal changes, ischemic toes, renal failure, anemia and eosinophilia.[28] However, the finding of cholesterol emboli in the bone marrow does not necessarily mean that the patient is suffering from widespread manifestations of this process.[29] It may be an incidental finding of minor clinical significance indicating that the patient has ulcerating aortic arteriosclerosis.

It cannot be emphasized enough that core biopsy of the marrow is indicated in all patients with hypercalcemia.[1] Many of the causes of hypercalcemia such as osteitis fibrosa, Paget's disease of bone, sarcoidosis, multiple myeloma and metastatic carcinoma can be readily diagnosed. Hyperparathyroidism can be easily diagnosed in a high percentage of cases from Jamshidi needle biopsies of bone and marrow (Fig. 6). In early or mild cases the characteristic clues are delicate and may be overlooked. They consist of mild focal endosteal fibrosis and an occasional osteoclast. The full-blown picture of hyperparathyroidism is easily recognizable. The osteoid seams are more prominent in secondary than in primary hyperparathyroidism. Early Paget's disease, in which the mosaic pattern of the bone is not prominent, can be differentiated from hyperparathyroidism by the greater vascularity of the fibrotic marrow and by the large size of the osteoclasts which contain more nuclei.

I hope that more of my fellow pathologists will get involved in obtaining bone marrow samples. It will give them a chance to obtain a history, to examine the patient and to review the laboratory data. The samples obtained, particularly the smears will be technically superior. Knowledge of the clinical data will help them decide whether to obtain bone marrow for histologic examination by core biopsy or by aspiration. It will make interpretation of the histologic findings more meaningful. The correlation of clinical, laboratory and histologic findings will build yet another bridge between anatomic and clinical pathology and will bring the pathologist closer to the patient and to clinical medicine.

References are available from the author upon request.

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Hodgkin's Disease and Non-Hodgkin's Lymphomas: Morphologic Features

Clarence C. Whitcomb, M. D. and Gerald E. Byrne Jr., M. D.

Abstract: Subtypes of Hodgkin's disease and non-Hodgkin's lymphoma can be consistently defined morphologically and are associated with specific clinical features. Morphologic classifications of these disorders are in a state of transition, however, as a result of recent advances in knowledge of the cellular biology of lymphoreticular cells. Current classifications are based upon specific histologic and cytologic features, and proper techniques for achieving optimal histologic preparations are mandatory for accurate morphologic evaluation of biopsies. Technical problems contribute to present diagnostic difficulties and non-reproducibility in the use of these classifications. Several new classifications have been proposed which attempt to relate current biological concepts to morphologically recognizable categories. While exciting and promising, none of the newly proposed schemata have yet been shown to be more useful or reproducible than currently familiar classifications.

During the past two decades truly spectacular advances in our understanding of the lymphoreticular system have resulted from investigations in several biologic disciplines. Immunologic, biochemical, and morphologic studies have all contributed important results.[1,2] The new information has already altered previous concepts of disorders involving the lymphocyte and monocyte-macrophage cell families which comprise the lymphoreticular system. New techniques of investigating and classifying such disorders are being intensively studied, and the resulting plethora of old and new terms and concepts has proved to be a source of considerable confusion for clinicians and pathologists alike.

Concomitantly there have been major improvements in the survival of patients with lymphoreticular proliferative disorders, specifically Hodgkin's disease (HD) and the group of disorders currently referred to as non-Hodgkin's lymphomas (NHL). The latter group includes the neoplastic disorders previously designated lymphosarcoma, reticulum cell sarcoma, and giant follicular lymphoma (Brill-Symmer's disease). These clinical achievements have been greatly facilitated by the formation of multi disciplinary health care teams which strive to effectively utilize the diagnostic and therapeutic approaches available. Effective teamwork has to date been more important than many of the new discoveries in the cellular biology of these disorders, but there is every reason to expect further advances in clinical management as the wealth of new information is applied in the clinical setting.



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This brief discussion of Hodgkin's disease and non-Hodgkin's lymphomas will review key morphologic features of these diseases which have been found to have implications useful for management. To contribute effectively to team management, pathologic classifications should reflect such clinically useful associations. It is beyond the scope of this discussion to review results and possible implications of the newer biologic studies, but several problems which currently complicate the task of pathologists who must provide morphologic evaluations to therapists are considered.

Technical Aspects of Diagnosis

Morphologic diagnosis of HD and NHL is based upon both histologic and cytologic features of the involved tissues. Tissue specimens must be carefully handled so that these features can be properly evaluated. Proper selection of tissue for biopsy is equally important. To insure that an accurate diagnosis can be obtained, both the surgeon and the pathologist should consider the following:

1. The biopsy should be taken from the lymph node group containing the largest lymph nodes. Inguinal nodes and posterior occipital nodes are frequently sites of chronic inflammatory processes. These processes can complicate the recognition of diagnostic features. When other sites are available, these two lymph node groups are best avoided.

2. A large lymph node in the involved group should be removed totally and intact. Because a node may be only focally involved by HD or NHL, and because the overall histologic architecture of the node must be evaluated, an adequate, intact specimen is essential. Incisional biopsies should be avoided, as should biopsies of small lymph nodes.

3. The intact lymph node should be delivered immediately to the pathologist without being placed in a fixative. To prevent drying, the tissue specimen may be placed in saline in a shallow, covered container or wrapped in wet gauze which is well-soaked with saline. Since the tissue is not in fixative, prompt delivery is essential.

4. "Routine" handling of the biopsy specimen, which usually implies placing the tissue in a fixative and delivering it to the pathologist several hours later, should be avoided. The tissue must be well fixed to preserve histologic and cytologic features. This is best achieved by prompt, careful dissection of the fresh specimen by the pathologist. The specimen should be cut into thin (2-3 mm) slices, and these slices fixed for at least 24 hours if neutral buffered formalin is employed. While cutting the node, the pathologist can prepare imprints from the fresh tissue. These imprint preparations can be used to further assess cytologic features of cells within the lesion.

5. Although a pathologic interpretation may be desired in less then 24 hours, a hurried approach frequently results in poor histologic preparations, which can render accurate diagnosis impossible. Frozen section examinations are best avoided; only if the result of a frozen section examination will alter the operative procedure contemplated at the time of biopsy is such an examination indicated. The freezing process causes considerable permanent distortion of cells which precludes accurate cytologic evaluation. Indeed, the most that the pathologist can deduce from a frozen section may be that a lymphoma is present; accurate classification is usually impossible. Finally, because considerable tissue may be consumed and altered during frozen section preparation, subsequent evaluation of properly fixed tissue may be compromised.

Why should such emphasis be placed upon these technical aspects of tissue handling? In the experience of one of us (GEB), approximately 50% of the cases referred for review because of diagnostic uncertainty are problems because of one or more of the following: 1) a small, easily accessible but focally involved lymph node was biopsied rather than a large, totally involved node; 2) the lymph node was fragmented during or subsequent to removal, thus preventing evaluation of overall lymph node architecture, one of the important observations needed to differentiate benign from malignant disease; 3) the tissue was hurriedly processed; 4) the majority of the tissue was utilized for frozen section examination. If the majority of these problems could be eliminated, the diagnostic accuracy of pathologists evaluating biopsies would be improved.

Hodgkin's Disease

The morphologic diagnosis of HD is predicated upon the recognition of Sternberg-Reed cells (S-R cells) within the cellular proliferations of this disorder. The origin of these abnormal cells is still controversial. Recent studies have suggested that the S-R cells may be related either to monocytes or to B lymphocytes.[3-9] In addition to the well known "typical" S-R cell, these abnormal cells can appear in a variety of forms which share the common features of polyploidy and large inclusion-like nucleoli. Recognition of typical and variant S-R cells in association with other histologic features forms the basis for the classifications of HD.

In 1966 Butler and Lukes presented a six-category classification of HD.[10,11] A simplification of their schema to one having only four categories was subsequently proposed at a conference held in Rye, New York.[12] The simplified Rye modification is now widely employed and has proved very useful for planning and evaluating therapeutic protocols. The four types in this classification can be conceptually considered in two groups. The first

contains the single type designated nodular sclerosis, while the second group includes the remaining three types of lymphocytic predominance, mixed cellularity, and lymphocytic depletion.

Recognition of the *nodular sclerosis* type of HD is based upon the finding of collagenous bands (the sclerosis) which subdivide the cellular tumor mass into nodules. (Figure 1) Within the nodules one finds a characteristic S-R cell variant referred to as a lacunar cell. (Figure 2) "Typical" S-R cells can also be found, and the remaining cell population includes various mixtures of normal-appearing lymphocytes, plasma cells, eosinophils, and benign histiocytes. Nodular sclerosis is the most common type of HD, and it is associated with a relatively favorable prognosis.

The other three types of HD lack the characteristic collagenous bands of the nodular sclerosis type. Although the terminology of the classification focuses attention upon the lymphocytic componant of the proliferation, the three types are best distinquished by assessing the number of S-R cells present. "Typical" S-R cells are exceedingly rare in the lymphocytic predominance type, very frequent in the lymphocytic depletion type, and intermediate in number in the mixed cellularity type.

The *lymphocytic predominance* type is associated with the most favorable prognosis of all the HD types, but diagnosis of the entity is often difficult because of the paucity of "typical" S-R cells. Fortunately another S-R cell variant, designated the L & H cell, is more readily found in lesions of this type (Figure 3). The subtle cytologic features of this S-R cell variant are easily obscured in suboptimally prepared tissue sections, however.

The *lymphocytic depletion* type is typically characterized by an abundance of S-R cells of many cytologic forms. Lymphocytes, therefore, are relatively sparse (Figure 5). This type has the least favorable prognosis. *Mixed cellularity* HD (Figure 4) occupies an intermediate position with respect to the frequency of S-R cells. The prognosis of mixed cellularity HD is also considerably less favorable than that of the lymphocytic predominance type.

Cells cytologically similar to the S-R cells which characterize HD can occur in benign lymphoreticular proliferations such as infectious mononucleosis.[13] Erroneous morphologic diagnoses of HD have been rendered in cases of reactive lymphadenopathy, usually because the total cellular milieu within which suspicious cells are observed was not adequately evaluated. Technically poor histologic preparations can contribute to such problem cases by obscuring the overall architectural features and cytologic details which must both be evaluated for correct interpretation.



Fig. 1.—Nodular sclerosis HD. Bands of collagen separate cellular nodules. (x23)

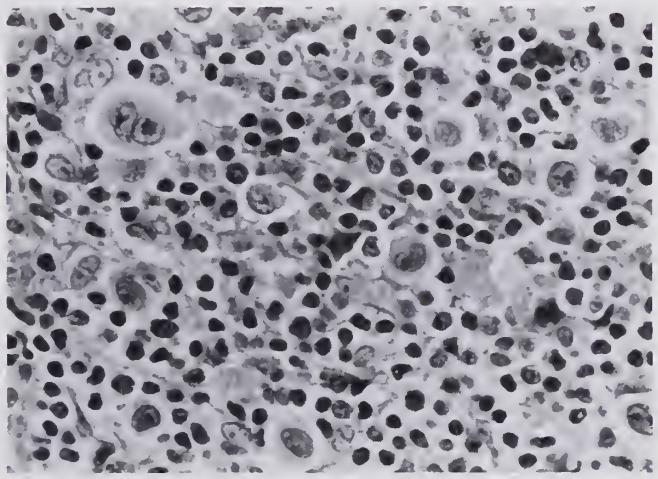


Fig. 2.—Nodular sclerosis HD. Lacunar cells (S-R cell variants) are admixed with normal appearing lymphocytes and plasma cells. (x400)

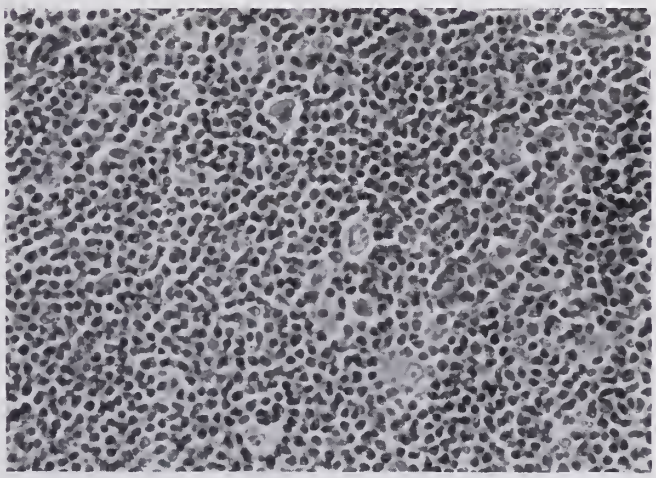


Fig. 3.—Lymphocytic predominance HD. L & H cells (S-R cell variants) are dispersed among normal appearing lymphocytes. (x250)

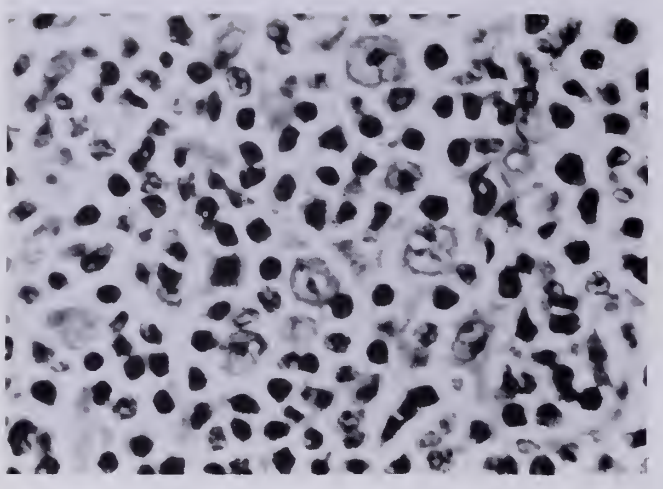


Fig. 4.—Mixed cellularity HD. "Typical" S-R cells and variants are numerous. (x400)

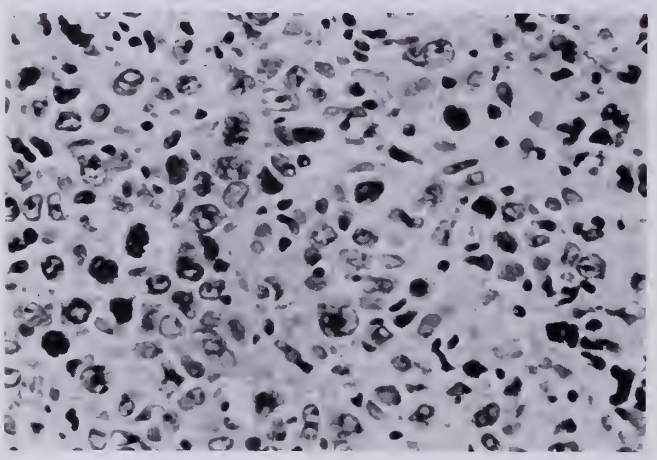


Fig. 5.—Lymphocytic depletion HD. S-R cells and variants are exceedingly numerous. Normal lymphocytes are relatively infrequent. (x250)

Non-Hodgkin's Lymphomas

The disorders included in the group designated non-Hodgkin's lymphomas are primarily neoplastic proliferations of B lymphocytes and T lymphocytes. Only rarely are proliferations of true histiocytes (macrophages) encountered.

The recent explosion of knowledge has caused considerable confusion in terminology employed for the lymphoreticular neoplasms. At present the most widely used schema for classifying these disorders is the classification of malignant lymphomas which was developed by Rappaport.[14] Although the original schema has undergone some minor modifications, this conceptual approach to diagnosis has proved quite useful.[15] The Rappaport classification still provides the most easily understood vehicle for communication between pathologists and clinicians.

In the Rappaport classification an important distinction is made between proliferations in which the cells are aggregated into distinct nodules-termed *nodular* NHL (Figure 6), and those in which no such aggregation is apparent—termed *diffuse* NHL (Figure 7). Further categorical divisions are based upon specific cytologic featues of the individual cells. As in HD, both histologic and cytologic observations are used to define subtypes within the spectrum of morphologic expressions of NHL. Terms for the types of NHL defined within the Rappaport system are summarized in Table 1.

As a group the types of NHL which have a nodular pattern have been demonstrated to have a relatively better prognosis than types in which the proliferation is diffuse, with one important exception discussed below. Within the nodular NHL group, determination of the dominant cytologic type also has had some prognostic significance.

Well differentiated lymphocytic NHL is a proliferation of small lymphocytes which have round nuclei with dense chromatin (Figure 8). The proliferation is usually diffuse in pattern. In contrast to diffuse NHL of other cytologic types, however, well differentiated lymphocytic NHL has a good clinical prognosis, being more favorable even than nodular NHL types.

The neoplastic cells of well differentiated lymphocytic NHL resemble the cells found in the peripheral blood and bone marrow of patients with chronic lymphocytic leukemia. Lymph nodes in patients with chronic lymphocytic leukemia and Waldenstrom's macroglobulinemia may be enlarged by a morphologically similar diffuse proliferation of small lymphocytes. Indeed, evaluation of peripheral blood cells, serum proteins, and immunoglobulins are frequently required for definitive diagnosis of morphologic lesions such as seen in this type of NHL.

Within the diffuse lymphocytic infiltrates found in the lymph nodes of patients with chronic lymphocytic leukemia or well differentiated lymphocytic NHL, one occasionally observes aggregates of large lymphocytes which may mimic germinal centers. During the course of the disorder in a small proportion of patients, these larger cells may become the dominant cell type. This progression from a proliferation of small lymphocytes to one of larger lymphocytes has been referred to as Richter's syndrome. Both the small and large cells are believed to be B lymphocytes, and the change in dominant cell type probably represents a transformation in morphologic expression of a single neoplastic disorder rather than the sequential occurrence of two different neoplasms.[16]

Poorly differentiated lymphocytic NHL is a proliferation of small lymphocytes which have distored, irregular, and angular nuclei (Figure 9). These cells are distinctly

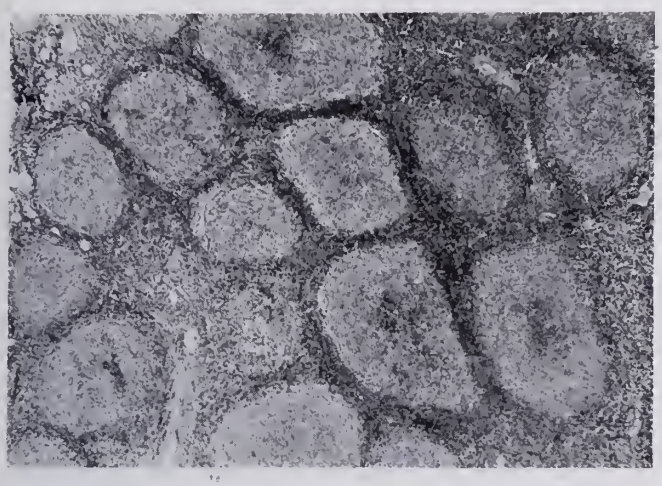


Fig. 6.—A nodular NHL. The proliferating cells are predominantly within the nodular aggregates. (x23)

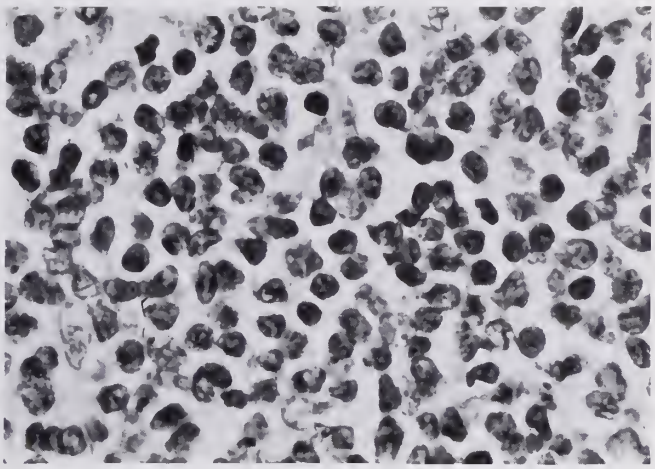


Fig. 8.—Well differentiated lymphocytic NHL. The small lymphocytes have generally round, dense nuclei. (x630)

NON-HODGKIN'S LYMPHOMAS (NHL)

Diffuse NHL	Nodular NHL
Well Differentiated Lymphocytic	
Poorly Differentiated Lymphocytic	Poorly Differentiated Lymphocytic
Mixed	Mixed
Histiocytic	Histiocytic
Lymphoblastic	
Undifferentiated, Burkitt's	
Undifferentiated, non-Burkitt's	

Table 1. Terminology used for morphologic types of NHL within the Rappaport classification.



Fig. 7.—A diffuse NHL. The proliferating cells are not organized into identifiable aggregates. (x23)

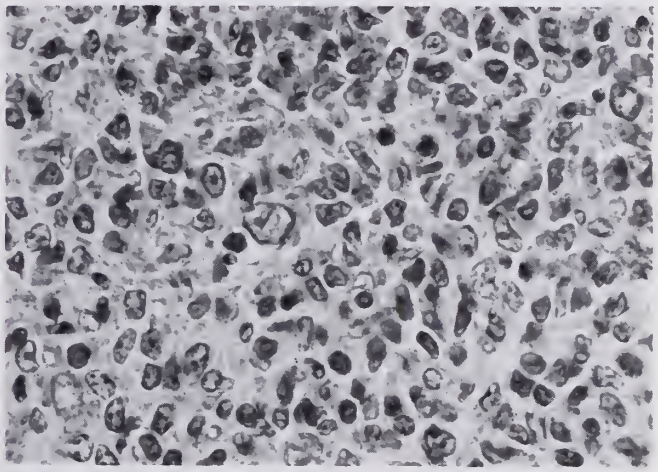


Fig. 9.—Poorly differentiated lymphocytic NHL. The small lymphocytes have irregular, angulated nuclei. (x630)

different in appearance from the cells of well differentiated lymphocytic NHL. The neoplastic cells of poorly differentiated lymphocytic NHL are frequently organized into a nodular histologic pattern, and when a nodular pattern is present, the prognosis is significantly better than when the proliferation is diffuse. Poorly differentiated lymphocytic NHL is the most common type of NHL.

Both well differentiated lymphocytic NHL and poorly differentiated lymphocytic NHL are usually composed of a single, predominant cell type. In some cases, however, the cellular population contains both small lymphocytes with round nuclei and small lymphocytes with irregular nuclei. Such cases have been termed lymphocytic lymphoma with intermediate differentiation.[17] The clinical significance of such a category has not as yet been determined. Evans et. al. have recently reported a series of cases in which they have used this same diagnostic term (intermediate differentiation), but the morphologic features of their cases differed from those described above.[18] Further studies are needed to precisely define a category of intermediate differentiation and to determine whether or not such a proposed category has any useful clinical associations.

The NHL of *mixed type* is a proliferation in which lymphocytes with large nuclei are admixed with small lymphocytes similar to those of poorly differentiated lymphocytic NHL (Figure 10). Either nodular or diffuse patterns may be formed. Because of the admixture of small and large cells, mixed NHL can mimic a benign, reactive follicular hyperplasia of lymph nodes when the nodular pattern is present. When the proliferation is diffuse, mixed NHL can be confused with the mixed cellularity type of HD. Careful attention to cytologic features may be required to assess the presence or absence of diagnostic S-R cells in such cases. Histologic tissue sections of high quality are essential in such problem cases.

Non-Hodgkin's lymphoma of *histiocytic* type is a heterogenous group of proliferations of large cells having nuclei which are as large or larger than the nuclei of true tissue histiocytes or endothelial cells (Figure 11). Although the term "histiocytic" is used for such proliferations, there is no doubt today that the vast majority of these large cell proliferations are really neoplasms of lymphocytes. The large cells have been shown to have immunologic properties similar to lymphocytes and distinct from the cells of the monocyte-macrophage family. Only a tiny proportion of large cell proliferations have appeared to be of true histiocytic (macrophage) origin.[19]

Histiocytic NHL usually occurs in a diffuse pattern, but nodular proliferation can occur. The histiocytic type is the second most frequent type of NHL. Among cases of NHL which arise in extranodal locations, however, the histiocytic type is the most frequent. Prognosis in cases of histiocytic NHL is generally poor, but some chemotherapeutic regimens have appeared promising for achieving and maintaining remissions.[20]

A diffuse proliferation of medium size lymphocytes in which the nuclei have markedly convoluted configurations was described by Barcos and Lukes in adolescents.[21] More recently Nathwani and associates reported a group of similar cases and emphasized similarities between these neoplastic lymphocytes and the blast cells of acute lymphoblastic leukemia.[22] A distinct clinicopathologic entity designated NHL, *lymphoblastic* type was established as a result of these observations (Figure 12). This type of NHL is frequently confused with the diffuse form of poorly differentiated lymphocytic NHL, and undifferentiated non-Burkitts lymphoma. Imprints made from unfixed lymph node or tissue specimens and stained with Wright-Giemsa stain are helpful in demonstrating the destinctive nuclear convolutions, which may be impossible to discern in suboptimally prepared tissue sections.

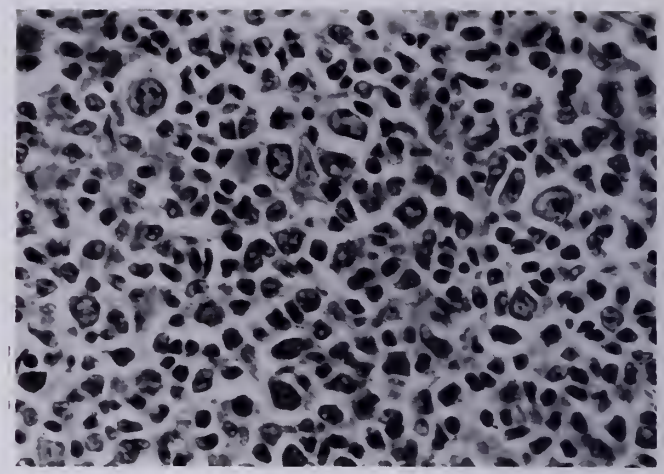


Fig. 10.—Mixed cell NHL. The admixture of small and large lymphocytes is prominent. (x400)

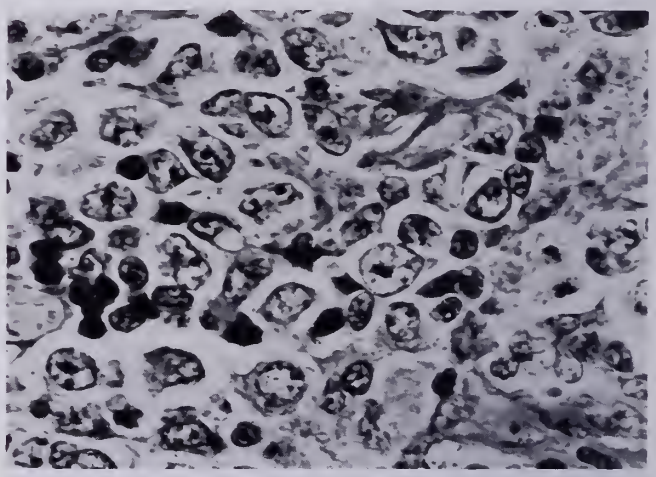


Fig. 11.—Histiocytic NHL. The large nuclei with prominent nucleoli and inconspicuous chromatin are the predominant feature. (x630)

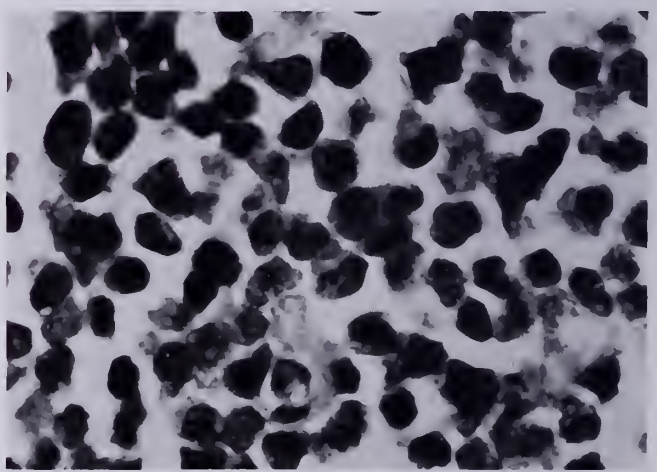


Fig. 12.—Lymphoblastic NHL. The convoluted configurations of the nuclei are not fully revealed in this photomicrograph, but foldings of the nuclear margin are visible. (x1000)

Lymphoblastic NHL occurs most commonly in adolescent males, and approximately 50% of patients present with a mediastinal mass. The bone marrow is frequently infiltrated early in the course of the disease, and hematogenous dissemination of the lymphoblastic cells frequently produces a clinical picture of acute leukemia.

The classification includes two additional categories—*undifferentiated, Burkitt's* and *undifferentiated, non-Burkitt's* types. The Burkitt's type is a well defined clinicopathologic entity in which tumor masses involve the pelvic and abdominal viscera, retroperitoneal soft tissue, and (predominantly in cases occuring in African children) the facial bones. They are composed of a rapidly proliferating population of lymphoid cells with uniform, round nuclei and easily visualized cytoplasm, which is characteristically pyroninophilic because of abundant RNA production. The neoplastic cells are believed to be related to the mitotically active cells of normal germinal centers. The non-Burkitt's type is not precisely defined at present. The term undifferentiated, non-Burkitt's has been most consistently used to categorize a proliferation of cells similar in many aspects to those of Burkitt's type, but displaying more heterogeneity in nuclear size and shape. The prognosis of both undifferentiated categories is poor.

Clinical Utility of Morphologic Classifications

In order for a classification to be useful, especially for evaluating therapeutic results, the same diagnostic categorization should be achieved consistently by different observers. Reproducibility of morphologic classifications have seldom been critically examined. The Rye classification of HD has been evaluated in this context.[23,24] In one study multiple pathologists achieved a very high degree of consistency in recognizing the presence or absence of HD, but agreement among them in specification of subtype was considerably lower.[24] Two studies have addressed the problem of diagnostic reproducibility in NHL utilizing the Rappaport classification.[24,25] Designation of the histologic pattern as nodular or diffuse was reproduced among observers with a high degree of consistency. When cytologic subtypes were assigned by the observers, however, agreement was achieved much less frequently (Table 2).

In these studies morphologic diagnoses were made from routine histologic material available at participating institutions. The measurements of reproducibility within the morphologic schemata employed thus represent the state-of-the art which can be achieved by pathologists using currently available histologic preparations. Because both histologic features and fine cytologic details must be recognized when using these classifications, improved reproducibility may be possible simply by improving the techniques of handling tissue specimens. Both surgeons and pathologists must assume responsibility for critical aspects of tissue handling as discussed previously.

REPRODUCIBILITY OF DIAGNOSIS-NHL

Cytologic Type of NHL	Diagnostic Agreement Among Observers	
	From Byrne[25]	Jones et. al.[24]
Well Differentiated Lymphocytic	72%	55%
Poorly Differentiated Lymphocytic	64%	49%
Mixed	69%	50%
Histiocytic	74%	61%
Undifferentiated	58%	—

Table 2. Reproducibility is measured as the proportion of observers selecting correct cytologic category using the Rappaport classification.

Within the past several years, five new classifications of NHL have been proposed.[26-30] Most of these continue to require fine assessment of cytologic features of the neoplastic cells. Most also attempt to relate morphologic categories to the results of other studies, such as immunologic properties of the component cells. The new classifications are conceptually exciting because they strive to identify neoplastic cells arising specifically from B lymphocytes, T lymphocytes, monocytes, or other functionally defined cell types. Nathwani has recently discussed the new proposals and has compared them to the Rappaport schema which is in general use.[31] Studies to assess the clinical association and usefulness of the new classifications are in progress,[32] but at the present time no one of the new proposals has been objectively demonstrated to provide more information of clinical usefulness than the familiar Rappaport classification. The classifications of HD and NHL presented thus still constitute the best general morphologic tools currently available for use in clinical management.

References are available from the authors upon request.

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Medico-Legal Death Investigation in Florida

Joseph H. Davis, M.D.

Government is expected to perform many functions and the most important is the protection of people and property. A core component of this vital function is the service performed by medical examiners, police, prosecutors and others in the criminal justice system. The medical examiner must determine the cause of death and assist in identification of the victim in order to establish the corpus delecti component of a criminal trial. As governmental agencies have become involved in non-criminal, accidental, suicidal, occupational and public health deaths so also have physicians acting as medical examiners.

Governmental interest in the cause of death of its citizens has a long history in Anglo Saxon law even before the written history of England. By 1776 the coroner of English law was established in the colonies and the concepts were carried through in the states as modified by statute and case law.

The complexities of deaths from injuries, poisonings, unrecognized disease, contagion and the physiological derangements resulting from interactions of man and the environment necessitated a mix of laboratory and clinical expertise to seek and interpret the complex cause and effect data. This becomes the role of a physician in the specialty of pathology or even the subspecialty of forensic pathology, that bridge between pathology and the political machinery of government.

Physicians as non-elected medical examiners were first noted in Massachusetts in the late 19th century but the system has failed to mature as witnessed by the Chappaquidick affair. In 1914 New York City established the first full-time centralized laboratory oriented facility because the elected coroner system had degenerated into a harmful farce. Gradually other metropolitan and small state systems followed suit. The contrast between the well served metropolitan areas and adjacent rural areas resulted in demands for improvement from frustrated police, physicians, and concerned citizens.

The first medical examiner system in Florida was established in Broward County by a special act of the 1951 legislature. This provided for a pathologist medical examiner to investigate certain specified deaths on a part-time basis. In 1956 Dade County became served with a full-time centralized facility which also included a toxicology laboratory. Eventually Broward County developed a full-time centralized service and other populous counties, Palm Beach, Orange, Duval, developed a variable degree of medical examiner service.

The physicians of Florida, acting through the Florida Medical Association and its Board of Governors, realized that the lack of uniform quality of professional investigation demanded a remedy. The legislative goal of the FMA was to establish a single-state statute upon which could be built an improved more professionally responsible system. In 1968 the FMA invited representatives from every conceivable agency or organization which could be affected by the presence or absence of medical examiner service. All law enforcement organizations, funeral directors, prosecutors and the bar associations, insurance organizations and medical subspecialties, were invited to participate. The FMA and the Florida Society of Pathologists each appointed a committee to review and criticize an initial bill. The committees met in concert. The joint meetings of the two committees represented a cross section of full-time and part-time medico-legal investigators and other physicians familiar with the



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legislative process. The role of each pathologist in the state in medico-legal death investigations was determined. The state comptroller records were reviewed and peace justice inquest expenditures were found to be quite high despite their lack of scientific validity. The committee was surprised to find that the state already had developed a "system." Pathologists in population centers tended to serve the surrounding counties on an ad hoc basis at the request of a state attorney. Established medical examiners likewise exerted an influence beyond county lines. When these were plotted on a map of Florida only a few blank spots were found.

The committee members agreed that state law should provide a basis for quality medical examiner service at least cost. The objectives to meet this goal were as follows:

1. The statute should not decrease quality and availability of service where such was already exemplary. Medical examiners should not be held to the lowest common denominator.
2. The medical examiner should be independent of police or prosecutors.
3. Independent single—or multi-county districts would best fit the diverse economic political and demographic mix. Availability of personnel to provide for these needs varied considerably. A single chief medical examiner could not assume responsibility for quality case investigation throughout a state where the half-way point between Key West and Chicago was Pensacola. The shortage of pathologists interested and qualified to perform such service demanded that the medical examiner be as close to the investigation as possible with no restriction on multi-district cooperation.
4. Each district should be headed by a pathologist. The interactions of disease and injury are too complex for lay interpretations and require a physician for proper interpretation. Because the autopsy is a major investigative tool the pathologist is the best qualified physician for the job.

With continued assistance of the Legislative Committee of the Florida Medical Association Chapter 406 Florida Statutes was enacted in 1970. The act defined a series of deaths which reasonably should involve the public sector: criminal violence, accident, suicide, suddenly when in apparent good health, unattended by a practicing physician, in prison or police custody, in any suspicious or unusual circumstance, by poison, by disease constituting a threat to public health, by disease, injury or toxic agent resulting from employment, when a body is to be cremated, and even when a body is brought into the state without proper medical certification. In any of the above death circumstance, the medical examiner has the duty to determine the cause of death and the authority to carry out whatever examinations, investigations and autopsies as the medical examiner deems necessary in the public interest. For administrative purposes a commission was created to oversee the program. It was placed within the newly created Department of Health and Rehabilitative Services. With the energetic support of Dr. James B. Fulghum of the then Division of Health, the commission designated district boundries, assisted in gaining the support of pathologists and getting the system into operation. Districts vary in funding according to needs. Some are on a fee-for-service basis, others on a retainer basis, and the remainder operate as full-time components of local county jurisdictions.

Each district is responsible for its performance. The law removed any artificial barriers to good service thus allowing those districts which wished better service to achieve their desires.

It became easier to identify problems under the unified statute. Additional state monies were appropriated to augment local funding in 1974 because of wide discrepancy in service. These monies were earmarked only for improvement and allowed some districts to build facilities and others to hire necessary personnel. Although the system is not yet perfect the gains have been impressive when compared with the situation a decade ago. Florida is now able to embark on programs of data acquisition, blood alcohol studies in deceased drivers and service programs pertaining to specific problems such as sudden infant death. This has been accomplished with no major input of federal programs or monies. It exists as a model for those states covering large areas with scattered centers of population. The principle is local autonomy following guidelines established by a unified statute. The administrative overhead is nil, the commission being served by one staff assistant and a secretary. The majority of commission staff time involves assistance to individual district medical examiners, acquisition of data pertaining to the violent death burden of Florida, and coordination of educational programs.

A major problem is the ever present threat to emasculate the law in the name of economy, one such amendment being passed during a previous legislative session. This required a governor's veto in order to assure that quality and necessary investigations would continue. The Florida Medical Association is to be commended for its recognition of this vital need, its role in creating the statute and its continued support.

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The Role of the Medical Examiner In Determining Time of Death In Brain Dead Patients

Ronald K. Wright, M.D. and Andrew A. Ostrow, J.D.

The medical examiner's role in determining the time of death in a "brain dead" patient is both official and unofficial.

Officially, the medical examiner, a state officer, is required to determine the cause of death when a person dies of any of 12 categories of disease or injury.[1] The medical examiner is the only physician who *must* certify the cause, manner and time of death upon the death certificate in every case he investigates.[2] In addition, the statute states that the medical examiner, upon being notified of the death, "shall examine or otherwise take charge of the dead body."[3]

Unofficially, the medical examiner is a physician who daily encounters the law, lawyers and judges. Practicing forensic pathology, full-or part-time, he, more than any other physician, is in a position to bridge the often dreadful abyss which exists between the professions of law and medicine. "Brain death" presents both medical and legal problems with overlapping considerations. The medical examiner can help resolve the questions for both physicians and attorneys. He must often be an interpreter, explaining legal concerns to physicians and medical concerns to lawyers.

This article will clarify the meaning of "brain death" in law and medicine, identify the legal and medical questions and discuss the civil and criminal liabilities that might arise from continuing or discontinuing treatment of a "brain dead" body. We will not discuss directly the diagnostic criteria except to add that the Harvard Criteria and other maneuvers are capable of making the correct diagnosis.

Death has no statutory definition in Florida. Many physicians feel that a statute would solve "brain death" problems.[4] However, the apparent positions of the American Bar Association and the American Medical Association disfavor statutory definitions.[5] Both groups are concerned that a statute, purportedly addressing the legal question, might encroach substantially upon what is strictly a medical question. In addition, politics, at least historically, making both strange bedfellows and postmasters, often produces strange statutes. The Kansas Statute defining death rambles to ninety-one words, using both cardiovascular-respiratory and central nervous system criteria.[6] It is patently unclear.

The common law definition of death controls in Florida. A possible first source for determining such a



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definition is Black's Law Dictionary. It defines death as "The cessation of life, the ceasing to exist, *defined by physicians*, as the total stoppage of the circulation of the blood, and a cessation of the animal and vital functions consequent thereon, such as respiration, pulsation, etc." (emphasis added).[7] Thus an oft cited source, the dictionary, incorporates the medical definition of death to explain the legal definition.

This confusion of law and medicine exemplifies the larger confusion in the health field where lawyers become involved in making medical decisions for which they are untrained creating an obvious danger for both patients and physicians. As a consequence, physicians—sensing the encroachment and recognizing the fatuous advice which they receive—react by making legal decisions for which they, too, are untrained. While an abyss exists between the professions, there is often not even a crack separating questions of law and medicine. Rather to digress further on the immensity of this problem, it would be prudent to focus on how the two professions interact to reach the decision to terminate an artificially supported body.

To separate the issues of law and medicine, one must first analyze and dissect the questions. A patient undergoing intensive care, maintained by modern technology, can be concluded to be alive—or dead. (The state of death is in reality a metaphysical concept. We can attempt to use such criteria as the Harvard tests to conclude death for medical or legal purposes.) Such a single medical-legal conclusion, however, can be subdivided into two legal and three medical questions.

The legal questions:

1. Is death the total and irreversible cessation of all brain function?
2. Is it a physician's duty to continue therapy upon a dead patient?

The medical questions:

1. What are the criteria for diagnosing total and irreversible cessation of all brain function?
2. Does this patient satisfy those criteria?
3. Having diagnosed death, when do we stop treating?

Dade County physicians discontinue cardiopulmonary resuscitation approximately ten times a day. In each of these cases cardiopulmonary resuscitation (CPR) resulted in pulse and respirations. Therefore, discontinuing CPR, in the eyes of the law, is the same as stopping the respirator of a brain-dead patient. Termination of CPR takes place without lawyer intervention. Physicians have been willing to shoulder alone the medical questions involved, probably because of the rapidity with which decisions must be made.

Physicians in Dade County terminate treatment of an intensive care patient whose non-brain organs are functioning but whose brain is not and is "brain dead," approximately once a day. Attorneys often are making medical decisions in these cases. This occurs because of the physicians' time lag which allows intervention by attorneys and hospital administrators. A minority of hospital administrators, upon advice of a minority of counsel, direct their physicians to continue therapy. A minority of physicians follow these directions.

When the medical examiner has jurisdiction, if death has occurred and has been pronounced by the usual standards of the medical community, he may step in and remove the body from intensive care, ordering discontinuance of any further touching of that body.[8] This requires the medical examiner to operate simultaneously, in both his official and unofficial capacities.

Officially, he is acting to prevent any further deterioration of the body, deterioration that might interfere with his ability to determine the cause of death to a reasonable certainty. The "respirator brain" is a well known entity to neuropathologists.[9] This condition entails a softened or liquified brain. To those of us who examine decomposed bodies, the only significant difference between the brain of a person dead in a lake for a week and that of one dead in ICU for a week is the smell. This decomposition of the brain may materially preclude determination of the cause of death by obscuring or eliminating pathological features of brain disease or injury.

Unofficially, as a physician concerned with law and medicine, he may be motivated to act to attempt to allay the fears of the medical and legal communities. Unfortunately, even widespread publicity of such situations has not solved the problem.

Two relatively recent reviews have dealt in some depth[10,11] with the medical questions involved in brain death.

The concern of physicians and the attorneys who advise hospitals appears to be an uncertainty as to the legal questions and fear of possible criminal and civil liability for discontinuing treatment.

As to the second legal question: Is it a physician's duty to continue therapy upon a dead person?

The consensus is that there is no such duty. The problem is not whether treatment should stop, but when. Termination of treatment should follow, not precede, termination of life.

Florida courts have not passed on the acceptance of brain death. Yet the first legal question: Is "brain death" death? has been answered in the affirmative in every appellate court decision in the United States, in the cases of criminal defendants who alleged that doctors—and not they—caused the deaths by pulling the plugs.[12] We have

analyzed the possible liabilities, both criminal and civil, for failing to stop, or stopping treatment of a brain-dead patient, should the Florida courts rule that brain death is not death. We shall assume in all cases that the physician has followed the accepted criteria and made the correct diagnosis.

If brain death is not legal death then legally the physician has caused a death by discontinuing therapy. Potentially, murder or manslaughter has occurred. Murder or manslaughter requires the state to prove beyond reasonable doubt that:

- a person died
- the death was the result of the criminal act of another
- the person who died was the person named by the state in the indictment of information.[13]

The first and third elements may be conceded in a brain death case.

For reasons beyond the scope of this article, there would be no legal basis for charging the physicians with murder since what occurred is the cessation of treatment, not the positive act of killing.[14] But even if a doctor was charged with murder for discontinuing treatment, a jury would have to decide that death was caused by the physician's criminal agency, best understood as evil intent. That could not be proven beyond a reasonable doubt. Expert testimony would cite as authority hundreds of articles medically defining death as brain death, demonstrating that the disconnection was perfectly proper.[10,11]

Although legally (remember, hypothetically) the doctor caused the death of a mechanically resuscitated body, it is not a *criminal* act of murder since murder requires "proof of a premeditated design" or an act "immediately dangerous to another and evincing a depraved mind, regardless of human life."[15] Manslaughter requires gross negligence to be proved, to satisfy the criminal agency part of homicide.[16] Again, irrespective of the legal question, as long as medical community standards were followed, there is no negligence, much less gross negligence.[17]

Discontinuing a mechanical respirator could also lead to a wrongful death suit.[18] The requirements for such a civil suit to proceed to trial and reach a jury are that:

- the defendent doctor owed a duty of care to the deceased
- the doctor was negligent in performing that duty
- the act or omission was the legal cause of an injury
- that the injury produced damages.[19]

Requirements one and three could be proved without difficulty. But to prove negligence would necessitate qualified expert testimony that the diagnostic criteria were wrong or misapplied or that cessation of treatment is not acceptable medical practice for a brain dead body. It would be difficult and very expensive to find a qualified expert to so testify. Negligence could be shown in a situation where a doctor improperly concluded brain death and pulled the plug. But damages to the survivors must be shown in a wrongful death case. And this would require expert testimony as to the deceased's expected survival, duration of survival and ability to support and provide services to the family. The probability of survival when mechanical resuscitation is required is so low that there is scant risk that damages could be proved.

Because the physician's behavior must be measured by medical standards, which unanimously favor making the brain death diagnosis and terminating treatment, it is our opinion that no liability would ensue, even if the courts were to rule that brain death is not death.

Picture a patient in intensive care, properly diagnosed as brain dead—but treatment goes on. Eventually, somatic death will supervene.[10,11] If brain death is not death, continued treatment cannot result in criminal liability. But there arises the possibility of civil action for battery. Protracted mechanical resuscitation is beyond the scope of any consent already given by the patient and, unless consent is given by the guardian, continued treatment constitutes battery—if the courts consider the patient legally alive. Consent for such treatment cannot be implied since the trend is to permit a patient to refuse therapy where prognosis is poor.[20] Moreover, failing to perform the diagnostic tests necessary to establish brain death, performing them improperly or continuing treatment without consent after diagnosing brain death is a negligent violation of the standard of care. A jury award could include not only the expenses of care and the pain and suffering of the family but even punitive damages.

If therapy is continued and the courts decide that brain death is legal death, there is probably no criminal sanction. There is, however, a strong possibility of civil liability for the so called "dead body tort."[21] Interfering with the family's right to bury its dead is the heart of this tort.

Florida cases—the most recent a suit against the Dade County Medical Examiner's Office—suggest liability is conditioned upon gross negligence before a family's pain and suffering will be compensated.[22] Proving gross negligence is difficult, but is clearly a jury question in a "failure to discontinue" case. If brain death is legal death, discontinuing treatment after diagnosis is the clear standard of care. And it now costs approximately $2,000 a day to maintain a brain dead patient, actual money damages flow to support the potentially massive pain and

suffering which may further inflame a jury to find gross negligence.

The medical questions about brain death have been decided for more than a decade.[10,11] The legal questions are not resolved in Florida. We have examined the legal possibilities and conclude that discontinuing treatment of a brain dead patient entails no risk of criminal liability and no significant risk of civil liability—whatever the outcome of the legal questions. However, to continue treatment of a brain dead patient, without proper authorization, does entail a significant risk of civil liability.

The role of the medical examiner will continue to be that of assisting Florida physicians in problem solving at the intersection of law and medicine.

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Neonatal Screening for Congenital Disorders

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Several congenital disorders that adversely affect the human neonate are either preventable or can be ameliorated with early therapeutic intervention. A variety of prenatal and perinatal screening measures are available to identify the infants at risk and permit a reduction in the mortality and morbidity caused by these disorders. The routine screening of pregnant mothers for syphilis has all but eradicated congenital syphilis, while public health measures to reduce the pool of potential mothers at risk for rubella has reduced the incidence of congenital rubella. The widespread use of passive immunization of rhesus negative mothers with Rh immune globulins upon delivery has greatly reduced the number of newborns with erythroblastosis fetalis while aminocentesis allows for careful monitoring and management of the fetus with Rh disease. The mass screening for phenylketonuria has done much to diminish the deleterious effects of one form of severe mental retardation. An increasing variety of chromosomal, structural, and inherited metabolic diseases may be diagnosed in utero, allowing for the consideration of therapeutic abortion or prenatal therapy of affected fetuses. Following the tragic experience with thalidomide, the public has become aware of the inherent dangers of alcohol, narcotics, radiation, and therapeutic agents on the unborn infants. Notwithstanding, there remain a considerable number of infants with congenital disorders who are not being adequately diagnosed and treated. Many of these conditions are either rare or difficult to diagnose in their early stages, when appropriate therapy



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might have prevented irreversible brain damage or even death. At least in the past, perinatal health care was assigned a low priority by politicians, and State and Federal resources were inadequate for programs to improve the outcomes of affected infants. The purpose of this article is to review neonatal screening measures, in the knowledge that their successful application will both prevent needless human wastage, and reduce the cost of institutionalized care required for the undiagnosed and untreated infant through adulthood. In his Croonian lectures of 1908, Garrod remarked, "It is the desire of everyone today, to prevent the appearance of obvious morbid symptoms." The successful application of screening programs will provide the tools to approach this goal.

Current Status in Florida

The State of Florida is in the process of expanding its infant screening program for inborn errors of metabolism and consolidating it in the Department of Health and Rehabilitative Services Laboratory in Jacksonville.* Besides the continuance of phenylketonuria (PKU) screening, additional tests for congenital hypothyroidism, galactosemia and Maple Syrup Urine Disease (MSUD) are being incorporated. The success of such a program will depend on the participation of all those involved with health care delivery to children. Pediatricians need to become familiar with the quality of the program and learn how to manage the care of infants with positive screens in terms of definitive diagnostic procedures, treatment of infants with positive diagnoses and routes of referral. With these needs in mind, the current knowledge about these four genetic diseases will be emphasized within this review. Since further expansion of the State's program is possible, other metabolic disorders which could be included in a mass screening program, will also be discussed.

Phenylketonuria

Classical phenylketonuria, resulting from a deficiency in hepatic phenylalanine hydroxylase, causes elevations in plasma phenylalanine and increases in phenylpyruvate excretion. The association of PKU with retardation of mental development in the neonate has been well established and screening tests for its early detection are the most universally available. The most common method of detection for the excess phenylalanine is the Guthrie bacterial inhibition assay (GBIA). The principle is that a filter-paper disc of dried blood, when placed on an agar plate, stimulates bacterial growth if phenylalanine is present to counteract the inhibitory effect of a phenylalanine analogue. The diameter of the bacterial growth circle is directly proportional to the concentration of the amino acid, so that the method can be used for serum monitoring as well as for mass screening of neonates.[1] The criteria used to confirm a suspected case of PKU are a blood phenylalanine concentration of 20 mg/dl (normal: <4 mg/dl), a tyrosine of less than 5 mg/dl, and a positive response to a phenylalanine challenge after a low phenylalanine diet has been established.[2] Using these criteria, the incidence rate of PKU is 1 case in every 15-20,000 newborns in the U.S., with lower frequencies among American Indians and Blacks. It is important to realize that a phenylalanine level of 20 mg/dl is rarely reached in a phenylketonuric infant before 7 days of life.[3] With the trend towards earlier discharge of newborns, most blood samples for screening purposes are taken during the first three days of life, resulting in a 8-10% rate of false negatives for PKU identification.[4] The solution to this problem is a follow-up test after 1 week of life, but this has not been adopted in most states for economic reasons and is therefore left in the hands of the primary physician. A 4-6 mg/dl level is frequently used to identify the test as presumptively positive, and yields 20 false positives for every infant subsequently proven to have PKU.[5] Two-thirds of the infants with this initial moderate elevation possess a benign hyperphenylalanine variant which is often compatible with normal development.[6]

The discrimination of variant forms of hyperphenylalanemia may be made on the basis of associated phenylpyruvate excretion (normal with plasma phenyalanine levels over 1 mM or 16.5 mg/dl), or the absence of phenylketones. The former tend to cause mental retardation unless treated. Further distinction may be made to separate probable classical homozygous PKU from heterozygous or variant PKU, based on the molar ratio of phenylalanine to tyrosine. We suggest that these diagnostic decisions be left to experienced centers. The initial rate of positives for PKU screening is approximately 1 case in every 1,000, and with approximately 100,000 births per year in the State, a case load of 100 PKU follow-ups should be expected annually.

PKU is clearly associated with mental retardation. Some 90% of all untreated phenylketonurics have IQ's of less than 50.[7] Although the genetic defect can not be corrected, the resultant retardation can be prevented or ameliorated by the institution of a low phenylalanine diet containing 250-500 mg of the amino acid daily. Variant forms may allow tolerance of higher amounts, however plasma levels of phenylalanine need to be closely monitored. The best results are obtained when the treatment is initiated prior to the third week of age.[8] The PKU Collaborative Study, which was organized with the help of the Children's Bureau, has reported a mean IQ of

*Any questions concerning the State of Florida neonatal screening programs should be directed to Dr. Nathan J. Schneider, Department of Health and Rehabilitative Services, Jacksonville, Florida.

93 + 16 (S.D.) for 111 children with PKU treated by 2 months of age.[9] This same group and others have studied the question of whether, and when, the low phenylalanine diet can be terminated. The issue is still far from being resolved, but in general, an easing of the diet at 5 to 8 years with subsequent careful monitoring of the child's performance and behavior is the most frequently recommended approach.

The successful diagnosis and treatment of PKU in several individuals now leading relatively normal lives, emphasizes the value of the screening process. Unfortunately, if homozygous PKU women become pregnant, their high blood levels of phenylalanine cross the placenta and cause defective brain development in the fetuses.[10] The screening of women of childbearing age is carried out in Massachusetts and Maryland since they were not screened as infants. There is some promise that dietary control during pregnancy in these cases can allow normal development of the fetus,[11] but more definitive studies are needed.

Maple Syrup Urine Disease (Branched-chain Ketoaciduria)

There are at least four conditions known as maple syrup urine disease (MSUD). Each is associated with a deficiency in the oxidative decarboxylation of the alpha-ketoacids of leucine, isoleucine and valine, resulting in the accumulation of these three branched chain amino acids and their respective ketoacids.[12] The method used for the mass screening of this disease is a bacterial inhibition assay (BIA) for leucine[13] and is readily added to established PKU screening programs. A leucine level of greater than 4 mg/dl followed up with a value greater than 20 mg/dl by the fourth day of life, is diagnostic of the classical and most severe form of the disease. The combined frequency of the various traits of MSUD is only about 1 case per 250,000 live births, however MSUD is a more serious and acute disease than PKU, since the ketoacids in MSUD rapidly accumulate and cause neurological damage much earlier than seen with PKU.[12] Snyderman and others have suggested that therapy must be instituted within the first week to prevent permanent neurological damage. In the absence of screening and successful early treatment, 95% of the patients will die in early infancy. The demands on a mass screening program for rapid sampling, testing and reporting are therefore very high if the overall effort is to be worthwhile.

The dietary treatment of MSUD is more difficult than for PKU, since three essential amino acids are involved in the disease and there is no indication as to when, if ever, dietary restrictions may be eased.[12] Effective therapy may also result in amino acid deficiency states. Many still question whether screening for MSUD is financially and morally justifiable. The cost of screening for MSUD in conjunction with a PKU program is low. However, the cost of treatment of MSUD, perhaps for a lifetime, is high and in the absence of screening, the MSUD patient will usually not survive. The point is made as follows by Guthrie:[13] "The long-term financial burden of raising and caring for a mentally retarded child, such as children having PKU . . ., is generally nonexistent in MSUD. This makes it more difficult to justify screening for MSUD simply on a . . . cost-benefit basis. It therefore becomes a matter of attempting to place a value on the preservation of human life, which in turn must be balanced by a consideration of the quality of life of MSUD patients undergoing life-long treatment with a synthetic diet."

Galactosemia

There are two disorders of galactose metabolism which comprise galactosemia. They occur at the first and second step in the metabolic conversion of galactose to glucose, by the enzymes, galactokinase and galactose-1-phosphate uridyl transferase respectively. The clinical manifestations of the disease seem to be due to the excess accumulation of galactose-1-phosphate and galactitol.[14] In the transferase deficiency, the neonate presents with failure to thrive, vomiting, liver disease, bruisability, cataracts, and mental retardation. They also show a susceptibility to bacterial sepsis which leads to death in 30% of the untreated cases.[15] The kinase deficient trait is a less serious disease leading mainly to cataract formation, often during infancy. The reported incidence of galactosemia is about 1:62,000.[16] There are three methods for galactose analysis which are adaptable to mass screening. One BIA technique differs from the tests for PKU and MSUD, in that a positive test is noted by growth inhibition instead of stimulation. This method has a disadvantage in that the mutant bacteria used tend to lose their sensitivity to galactose.[16] Paigen and Pacholic[17] have developed a stable bacterial assay which shows growth in the presence of galactose. It has also been modified to respond to glucose-1-phosphate, the immediate precursor to the transferase block. The method therefore has greater sensitivity and can be performed on filter paper samples of cord blood, thus allowing for earlier screening of the disorder. Since the transferase is normally present in erythrocytes, an enzyme spot test on the blood eluted from a filter paper disc was designed by Beutler and Baluda.[18] The most serious problem with this test for mass screening has been the number of false positives due to activity loss incurred during the transport of specimens.[16] Galactosemia is similar to MSUD with respect to the demands it puts on the screening program because of it's high mortality rate. The specimen should be collected before the fourth day of life with rapid subsequent testing and reporting. In Massachusetts, cord blood is tested by the Paigen assay, and followed by a repeat test on the heel

stick sample submitted for the PKU and other BIA screening tests. The State of Florida plans to utilize the Beutler enzyme spot test.

For patients that survive the earlier problems of this metabloic disorder, the most significant outcome is mental retardation with moderately affected IQ's.[14] The treatment for galactosemia is the elimination of lactose-/galactose from the diet indefinitely. The most successful developmental outcomes have been claimed in cases where galactosemia has been suspected prenatally and where the mother was maintained on a galactose free diet.[19] The kinase deficiency may be diagnosed in suspected cases (cataracts) by determination of erythrocyte galacto-kinase levels.

Hypothyroidism

Congenital hypothyroidism is the most common preventable cause of mental retardation, with an incidence of about 1 in 5,000 births.[20] This sporadic disease is infrequently diagnosed at an early enough age to allow optimum therapy without the aid of a screening program.[21] Radioimmunoassay techniques are available to effectively screen for congenital hypothyroidism on the basis of concentrations of thyroxine (T4) and thyroid stimulating hormone (TSH) in either cord blood or in dried filter paper blood samples collected for PKU screening. In most programs, daily batches of T4 assays are performed and a predetermined percentage of the samples with the lowest T4 results are retested for TSH concentration. Patients with suspected abnormalities in the T4 (<6.5 g/dl) and TSH (>20 ng/ml) are then recalled for resampling and confirmatory testing on serum. The actual levels must be determined by individual laboratories. Programs of this nature have a recall rate of approximately 1%.[22] A particular problem is the physiological rise in T4 levels after birth and the lack of consideration of timing of the sample in relation to given normal ranges. The approach chosen by the State of Florida, is the combination T4/TSH testing of the PKU sample, which screens for more than primary hypothyroidism, but has the disadvantage of generating anxiety in the families of the infants singled out for reinvestigation because of this high recall rate. Low T4 levels may occur transiently in premature infants, and in otherwise normal infants with dominantly inherited deficiencies of TBG. No therapy is required for the latter infants. Foley and more recently Illig[23] have proposed a screening approach which monitors the TSH concentration in the dried blood spot as the initial test. This approach creates a lower false positive rate, but likewise, has a disadvantage in that it misses cases of secondary hypothyroidism (TSH deficiencies) which have a reported incidence of 1:60,000.[24] The latter group may not be at such risk for retardation however.

The early diagnosis and treatment of congenital hypothyroidism with thyroid hormone has been shown to be effective in preventing mental retardation, with the most successful treatments being those that are initiated prior to 6 weeks of age.[23] Screening programs will often not detect infants with delayed onset hypothyroidism as seen in lingually displaced thyroids.

Other Screening Possibilities

More Bacterial Inhibition Assays

The Guthrie BIA technique has been successfully applied to the assay of three other amino acids, methionine, tyrosine and histidine. This allows for the expansion of a screening program to include testing for homocystinuria, tyrosinosis and histidinemia, and indeed this has been done in various programs throughout the world. The simple availability of a test, however, does not automatically make it a good candidate for screening. There needs to be sound evidence that the metabolic error will have serious effects in the newborn, that it occurs at a reasonable frequency and that there is a satisfactory therapy available to prevent or ameliorate the effects of the disease. These criteria are not well established for these diseases. At the present time, there is neither a consensus on the frequency with which histidinemia is associated with clinically recognizable defects, nor on the effectiveness of dietary restriction.[25] The incidence of tyrosinosis seems to be extremely rare,[26] except among French Canadians. In fact, Gaull and colleagues have questioned the specificity of the diagnosis of "hereditary tryosinemia" since non specific liver disease in the newborn induces high plasma levels of tyrosine and methionine, while prematures show varying degrees of intolerance to tyrosine. The complications of homocystinuria of lens dislocations and thromboses are serious, but the ability to successfully improve the outcome as a result of early detection has rarely been shown,[27] although occasionally a vitamin responsive form of the disorder has been detected and successfully treated.

Chromatography Techniques

Paper and thin-layer chromatography techniques enable the detection of several metabolites simultaneously, and would seem more efficient for multiple disease screening than would a series of bacterial inhibition assays. However these chromatographic techniques are less sensitive and more costly than BIA analyses, and to date have not displaced the agar plate approach for the amino acids disorders already mentioned. The Massachusetts program does use paper chromatography for urine screening, utilizing filter paper samples mailed in by

parents of 3 to 4 week old infants. Several in-born errors of metabolism in addition to those detected earlier by BIA techniques were observed.[27] Three of the disorders found most frequently, were iminoglycinuria, histidinemia and Hartnup disease with frequencies in the 1:10-20,000 range. It was concluded from this study, that these latter defects were more benign than originally thought, since many of the infants had no clinical symptomatology. This technique did, however, detect the serious metabolic disorders, argininosuccinic acidemia and non-ketotic hyperglycinemia. The success of this program indicates the utilization of paper chromatographic screening may be beneficial as an adjunct to the BIA and RIA methodologies in the comprehensive screening laboratory.

Gas chromotography has been utilized by Watts[28] in order to screen for non-amino organic acidurias which account for about 50 of the known 180 single enzyme defects. This approach has not been proposed for mass screening on a non-selective basis, but may be useful as a diagnostic screen for all neonates presenting with a non specific illness and a failure to thrive. The utilization of gas chromatographic techniques will increase in the future, and the case for non selected screening of neonates will doubltless be reopened.

Radioimmunoassay in Cystic Fibrosis

Cystic fibrosis is the commonest serious genetic disease in Caucasian children with a frequency of about 1 case in every 2,000 births. The search for a mass screening test is active, and a number of techniques are being investigated. Ion specific electrodes for sodium and chloride in sweat or saliva need further technological development since they yield a high frequency of falsely positive results.[29] Tests for elevated levels of protein in meconium spotted onto filter paper[30] appear to be adaptable for mass screening, but a report of 40% false negatives[31] due to transportation artifacts is a serious limitation to its use. Immunoreactive-trypsin (IRT) assay by radio-immunoassay (RIA) on eluted dried blood spots has been proposed as a screening test.[32] Preliminary evidence shows that the elevation of IRT in the newborn with cystic fibrosis is readily distinguishable from normal levels. This approach could be readily accommodated into any program already utilizing RIA methods for hypothyroidism screening, since it would use the same sample. Pilot studies to investigate the feasibility and reliability of this test are needed.

Enzyme Analysis

Although the diagnosis of Duchenne muscular dystrophy (DMD) in neonates is of no practical advantage to the infant involved, it would, except in the case of spontaneous mutations, identify the carrier state in the mother. This may be useful for genetic counseling purposes, since further sibling births may take place before the clinical diagnosis has been made in the proband. A method for creatine kinase quantitation on blood eluted from a dried blood spot has been proposed as a screening technique for DMD that could be accommodated into existing programs.[33] In a pilot study, 9 myopathic children were successfully detected out of 109,000 screened. Mass screening for DMD, however is not universally acceptable because of the lack of an effective therapy. Many feel that the development of tests for maternal heterozygosity and prenatal detection are more worthy of future research efforts than the establishment of mass screening programs on all newborn males for genetic counseling purposes.[34]

The screening of plasma hexosaminidase A levels in Ashkenazi Jews, enables accurate genetic counseling for Tay-Sachs disease. Heterozygous couples may elect not to have their own children or may have in utero diagnoses, allowing for therapeutic abortion of affected fetuses. Other lethal diseases may be eliminated by such means when suitable screening tests of potential parents becomes available and the risk is deemed sufficiently high in certain populations to warrant the effort. Sickle cell disease in Blacks or thalessemia among persons of Mediterranean descent seem to be potential examples.

Histocompatibility Antigens

With the recent demonstration by Irvine, New and colleagues that all siblings of individual families with the 21 hydroxylase type of congenital adrenal hyperplasia were HLA identical, the prenatal diagnosis of this disease in a second sibling from HLA typing of amniocenteses cultures is now possible.:[35] This may have practical application when such deliveries are contemplated away from expert neonatal medical care. HLA typing is of no diagnostic value for the disease otherwise. The feasibility of identifying newborns at risk for HLA associated autoimmune disorders, seems also to be plausible but requires extensive study.

Summary

Advances in the care of pregnant mothers and their infants have improved infant mortality and morbidity rates, due in large measure to improvements in nutrition and in the managements of infections. In Western countries, congenital and/or inherited metabolic diseases now lead the list of serious diseases of the newborn. The screening of parents at risk for affected off-spring can reduce the number of these infants coming to term. The newborn can be screened for many congenital disorders in which early therapeutic intervention may spare them serious sequalae. The time to consider the

practical issues involved to warrant screening for particular diseases is now at hand. The issues include the disease prevalence, the severity, the cost-benefit ratios, and the availability of proven measures which would significantly alter the outcome. The expansion of screening programs to include more diseases will surely follow advances in diagnosis and management and continue to change the face of pediatric and obstetric practice.

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References are available from the authors upon request.

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Pediatric Nuclear Medicine

Dorothy Lloyd, M.D.

The use of nuclear medicine imaging procedures in studying disease in children has grown progressively over the years and expands in scope as new radiopharmaceuticals and new equipment become available, and new methods are developed. Certain nuclear medicine procedures, because of their non-invasive nature and high sensitivity, are particularly applicable to the pediatric patient. The need for limitation of radiation dose, as well as problems related to dose administration, immobilization and positioning small patients in this age group,[1] make it essential to choose carefully the appropriate procedure which may be used most efficiently in evaluation or diagnosis of the individual patient's problem. The uses of selected procedures in relation to a few fairly common diagnostic situations are presented in this paper.



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Trauma

Radionuclide spleen scan can be valuable in the diagnosis of laceration, rupture or hematoma of the spleen with an accuracy up to 90%.[2] The presence of a defect on the scan is, of course, non-specific, but when interpreted with pertinent clinical data and a history of blunt trauma to the abdomen, may be considered adequate evidence of splenic injury. False positives may occur due to the presence of a pre-existing lesion, congenital or anatomical variations in splenic configuration, or misinterpretation of a normal scan. False negatives can result from delayed rupture or a pattern of diffuse subcapsular hemorrhage producing a relatively normal splenic outline. The increased risk of serious infection in splenectomized children makes it desirable to avoid splenectomy unless absolutely necessary; thus, in children with suspected splenic trauma, the spleen scan can be used to evaluate the type and degree of injury, and in cases with no evidence of continued intraperitoneal bleeding, a conservative non-operative course may be elected. In the case of the questionably abnormal scan, an arteriogram may be necessary to help solve the dilemma. In those cases managed conservatively, the spleen scan may be used for follow-up to rule out enlargement of the defect or to follow resolution of the

abnormality if it occurs.[3] Some defects will persist for years, a few will resolve completely, and others will show only minimal residual defect (Fig. 1). When imaging the spleen, it is worthwhile to also evaluate the liver, as an occasional traumatic lesion may be found there.

Bone scans become positive within hours following trauma, more rapidly in children than adults. Focal activity in the fracture site may be seen as early as 12 to 15 hours following injury, growing in intensity for 3-7 weeks, then subsiding gradually over a period of months to years. The time table is inexact, related to age, physiologic conditions in bone, blood supply, related soft tissue injury and type of fracture. Because of these factors, it is not possible to accurately determine the age of a fracture by scan appearance alone, other than in very general terms; however, absence of focal concentration 3-5 days after injury virtually excludes fracture.[5] Many studies have shown small or incomplete fractures, such as stress fractures, may produce positive bone scans long before radiographs become positive.[6] The scan, when positive, with appropriate clinical signs and symptoms, is adequate evidence for stress injury, even if x-rays remain negative. When imaging special areas for suspected trauma, it is useful to perform a whole body bone scan, as other unsuspected injuries may be detected, particularly in athletic injuries, accidents or a child abuse situation.



Fig. 1. —Teenager with a history of trauma. (a) Note the defect in the spleen. (b) Two weeks later the spleen appears normal.



Fig. 2. —Bone Scan in osteomyelitis. Five year old female showing areas of increased activity in the right proximal femur and right mid femur.

Infection

Early diagnosis detection of osteomyelitis with prompt institution of therapy increases the probability of recovery without crippling sequelae. Bone scintigraphy, usually characterized by focal intense activity in involved areas, helps to detect and localize the infectious process in the early stages when x-rays are negative or non-specific. As osteomyelitis may result from direct extension from an adjacent focus of infection, or from hematogenous spread, it may involve single or multiple sites (Fig. 2). Hematogenous osteomyelitis, in affecting rapidly growing bone, may localize in the bone shaft or in the metaphyseal end of long bones adjacent to the epiphyseal growth plate.[8] The growth plates demonstrate physiologically increased activity; consequently this area needs special attention, and may be difficult to evaluate. "Cold" areas may occur very early in the disease when blood vessels are transiently blocked,[7] or in suppurative areas with necrosis and devitalized bone. A normal scan is evidence against a diagnosis of osteomyelitis.

The use of gallium scanning in diagnosis and localization of post-operative infection, abdominal or sub-phrenic abscess is well established.[9] The study is performed at 24 hours post-injection, although later confirmation of positive areas may be required, and is characterized by focal, intense, persistent activity in the involved area. Early scans may be performed at six to eight hours; however, it has been our experience that high generalized activity and early bowel concentration of gallium confuse the picture, and only occasionally are these scans diagnostic. Diagnosis of abdominal abscess with gallium approaches 90% accuracy, and when used in conjunction with ultrasound and computed tomography approaches 100% accuracy. A recently outlined diagnostic approach[10] consists of the use of gallium as the initial study in the evaluation of the patient suspected of intra-abdominal abscess, but without localizing signs or symptoms, followed by ultrasound or CT if needed (Fig. 3). However, in the acutely ill patient with localized signs and symptoms, in whom a rapid diagnosis is needed, ultrasound or CT directed toward the suspicious area is used as the initial study, followed by gallium if CT and ultrasound are negative or nonconclusive. An advantage of gallium, of course, is that unsuspected areas of inflammatory disease may be discovered due to the large anatomical area included in the study.



Fig. 3. —24 hour Gallium study in a 10 year old female, 15 days post appendectomy, revealed a left sub-diaphragmatic abcess, confirmed by ultrasound and surgery.

Other uses of gallium include the evaluation of possible renal inflammatory lesions, such as pyelonephritis or abscesses. Gallium may normally be seen in the kidneys at 24 hours, but persistence beyond that time indicates the presence of inflammatory or neoplastic cell infiltrates. Irregular or localized persistence within the renal parenchyma, particularly if used in conjunction with an agent such as DMSA for imaging defects, is excellent evidence for localized inflammatory disease. In view of the need for conservation of renal parenchyma in renal disease, which may often be bilateral in children and possibly associated with congenital abnormalities, gallium imaging may be a useful diagnostic procedure in the institution of early conservative therapy.[11]

Neoplasms

Neoplasms commonly associated with the pediatric age group include certain central nervous system tumors, leukemias, lymphomas, soft tissue sarcomas, Wilms' tumor, neuroblastomas and bone neoplasms. Depending on the neoplasm and its patterns of spread, nuclear medicine studies which may be helpful in initial evaluation and staging are brain, liver, bone and gallium studies.

In the search for possible central nervous system tumor, computerized tomography statistically yields the most information, as it has an accuracy approaching 99% in detection of neoplasms. Radionuclide brain imaging, however, provides information not available on CT scan, particularly in relation to vascular changes, arteriovenous malformations, abscesses, or encephalitis, and enhances information available as to tumor type;[12] thus a combination of CT and radionuclide imaging may be the procedure of choice. CT and/or radionuclide brain images are appropriate in all central nervous system neoplasms and in metastatic studies on other tumors if neurological signs and symptoms suggest possible brain involvement.

Tc 99m sulfur colloid radionuclide liver and spleen imaging has long been used for differentiation of hepatic enlargement, to evaluate the extent of primary hepatic neoplasms such as hepatocellular carcinoma and hepatoblastoma, and in staging of metastatic disease. Used as the initial diagnostic procedure, the sensitivity is around 90%; however, it is unable to differentiate between cyst, abscess, tumor or regenerating nodules in hepatic parenchymal disease, thinning of the left lobe, variations of porta hepatis and gallbladder fossa. In these cases, CT or ultrasound, and ultimately biopsy may be necessary to define the problem, if doubt persists. Liver and spleen imaging is an appropriate part of the work-up in primary liver tumors, Wilms' tumor, neuroblastoma, lymphomas, leukemias and soft tissue sarcomas (Fig. 4).

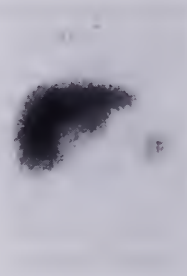


Fig. 4. —Liver scan on a 15 month old female revealed a mass lesion which on biopsy proved to be a hepatoblastoma. Patient is on chemotherapy and doing well seven months following resection.

Recent studies indicate that Ga-67 imaging may be gaining in use in evaluation and follow-up of pediatric malignancies. Paralleling what is known concerning adult neoplasms, gallium sensitivity is high in lymphomas, soft tissue sarcomas and bone tumors,[15] with varying rates of Ga-67 avidity in other tumors. Determination as to whether a tumor is gallium positive or not, should be done in the initial pre-treatment work-up, and if the tumor concentrates Ga-67, then serial studies may be used at appropriate intervals to detect recurrence.[14] These studies can be done during the course of radiotherapy or chemotherapy, and later as necessary. Persistence or recurrence of gallium-positivity is a poor prognostic sign, and may signal necessary alterations in therapy (Fig. 5). Because gallium may also concentrate in inflammatory lesions, including those caused by opportunistic organisms in immunologically depressed patients, positive areas should be confirmed by appropriate methods.

At least two papers[15,16] have suggested that Gallium-67 avidity may have prognostic significance in patients with neuroblastoma. In both studies, only 40-60% of neuroblastomas were gallium positive, but those that were demonstrated a poor prognosis, while those that were initially gallium negative were in clinical remission many months later. The prognostic value remains speculative at this point, but suggests a need for further study.

Radionuclide bone imaging made its earliest contribution in the evaluation of metastatic disease in the skeleton, and has proved over the years to be an early



Fig. 5. —Gallium study on a 5 year old male. The axillary mass, diagnosed as histiocytic lymphoma, was persistently gallium positive throughout therapy. Dissemination of the disease and death occurred within one year.

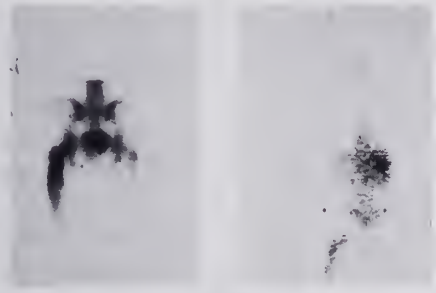


Fig. 6. —8 year old female evaluated for pain in the left femur. Bone scan and gallium scan suggested osteomyelitis or possible neoplasm. Biopsy eventually proved Ewing's sarcoma. a) Bone scan. b) Gallium scan.



Fig. 7. —One year old male with episode of rectal bleeding one day prior to admission. Note the focus of activity in the right lower quadrant consistent with ectopic gastric mucosa. Surgery confirmed a Meckel's diverticulum containing gastric mucosa in the distal portion. Ulceration was in ileal mucosa adjacent to the gastric mucosa.

and accurate detector of bony metastases with application in many pediatric neoplasms[17] which spread to bone, including lymphoma, soft tissue sarcomas, Wilms' tumor, neuroblastoma, and primary bone tumors. Its use in primary bone tumors such as Ewing's sarcoma and osteogenic sarcoma helps define the extent of the primary lesion, as well as determining if distant skeletal metastases have occurred. The expected reaction of bone in primary and metastatic neoplasms is that of focal, intensely increased activity in the involved area, although occasionally "cold" areas may be seen in primarily bone destructive areas. Because of the non-specificity of the reaction in the bone scan, x-ray correlation is necessary in the diagnosis of primary bone tumors, which may be confused with osteomyelitis on the scan alone. Ewing's sarcoma, particularly, may occur as a fusiform lesion in the metaphysis, quite indistinguishable from osteomyelitis, and can be difficult to differentiate, even on biopsy (Fig. 6). In a patient being evaluated for skeletal metastases from a soft tissue malignancy, the bone scan will show metastatic disease long before the x-rays become positive, and can be used as evidence of metastases (in appropriate clinical circumstances) without corresponding positive x-ray correlation.

Staging of neuroblastoma is important to management, as bone metastases indicate a poor prognosis.[18] Skeletal metastases from neuroblastoma are usually involved in the skull, long bones, vertebra, pelvis and ribs. A common pattern of spread involves the metaphyseal region of long bones adjacent to the epiphyseal growth plate, a pattern which requires special attention to evaluation of shapes of the growth plates. The bone image may provide useful information concerning kidney position, displacement or obstruction of the kidneys and ureters by the mass. Some primary neuroblastomas will concentrate Tc99m phosphate bone imaging agents, possibly because of calcification within the tumor, however in cases without calcification, the mechanism is not understood.

Congenital Anomalies

Radionuclide imaging can be used in detection of a number of congenital anomalies. Cisternography, used in the study of hydrocephalus, may also help pinpoint associated conditions such as posterior fossa cysts and porencephalic cysts. Nuclear cardiology is gaining acceptance in evaluation of congenital heart disease. Renal imaging and function studies can detect structural anomalies such as horseshoe kidney or absence of one kidney, as well as obstructive and reflux problems. Thyroid function tests are becoming routinely used as screening tests for congenital hypo-thyroid disease in neonate. Thyroid imaging is valuable in evaluating functioning thyroid tissue in neck masses or cysts. Congenital malpositions of the liver and spleen can be easily demonstrated by liver and spleen scanning, and evaluation of obstructive jaundice in the diagnosis of biliary atresia is aided by Rose Bengal I 131 studies. Abdominal imaging for ectopic gastric mucosa in a Meckel's diverticulum is a useful study in determining the cause of the abdominal pain or rectal bleeding in a child (Fig. 7).

References are available from author upon request.

• Dr. Lloyd, 1416 South Orange Avenue, Orlando 32806.

A Regional Blood Program for Florida

Glenn S. Hooper, M.D.

Abstract: A brief history of blood banking in Florida leading to current efforts at regionalization under the American Blood Commission and a narrative of the factors leading to the National Blood Policy—American Blood Commission are presented.

During late 1978 and early 1979 the Florida Association of Blood Banks made strenuous efforts to establish a statewide blood program which would (1) result in minimal disruption of Florida's existing fine blood banking institutions, (2) result in improved inventory sharing and coordinated donor recruitment, and (3) qualify for recognition as a Regional Association of Blood Service Units by the American Blood Commission. Let us review the histories of the organizations involved and the difficulties in establishing a statewide program.

Blood banking in Florida began with the charter of the Blood Bank of Dade County on March 26, 1941. The first blood bank in the world had been formed at Cook County Hospital in 1937 and the first community blood bank was the Irwin Memorial Blood Bank of the San Francisco Medical Society, which was organized in 1941. Dade County (later to be renamed John Elliot Blood Bank) was not far behind.

As the clouds of World War II gathered, the Medical Division of the Office of Civilian Defense in Washington had asked that communities establish regional plasma or blood banks throughout the nation. The Florida Health and Housing Committee responded by dividing the state into five districts (according to existing Congressional Districts) with a committee in each district to establish a blood bank.

The Dade County facility, which opened with 19 pints of blood and 4 units of plasma, now handles in excess of 100,000 units of blood and many thousand units of various components annually. In 1946, Dr. John Elliot became director of the organization which would later bear his name. The early blood bank prospered due in some part to the production and sale of typing serums. The typing serum operations were subsequently split away from the non-profit blood bank and became Dade Reagents, now a division of American Hospital Supply Corporation. In the early 1940's other regional banks formed were Tampa Blood Bank (now Southwest Florida Blood Bank) on March 10, 1942; Jacksonville Blood Bank, Inc. on March 17, 1942; the Orlando Blood Bank, Inc. (later Central Florida Blood Bank) in May, 1942; and the Chattahoochee Blood Bank, which prepared plasma in the State Hospital during the war, but discontinued operations after V-J Day. Escambia Blood Bank (now Northwest Florida Blood Bank) later became the regional blood bank for the panhandle district.

In 1946, interest was generating for formation of a statewide blood bank association. On May 25, 1947 representatives met in Jacksonville to organize a statewide blood and plasma program. Although the Florida Association of Blood Banks was not chartered until 1954, its roots go back to May of 1947 about five months prior to the organization of the American Association of Blood Banks. Representation in FABB is by districts which correspond to those originally set up during World War II.

The FABB pioneered annual meetings, workshops, and an annual inspection and accreditation program for its members. All of these programs were subsequently adopted by AABB. They were carried out in Florida originally by the large regional banks to aid smaller community banks and hospitals. Mrs. Dorothy C. Smith, R.N. of the Jacksonville Blood Bank became Executive



Dr. Hooper

The Author

GLENN S. HOOPER, M.D.

A graduate of the Medical College of Alabama, Birmingham, in 1960, Dr. Hooper remained there for internship and residency training, which was continued at the Medical College of Virginia. He was Associate Pathologist at St. Joseph's Hospital, Lexington, Ky., and since 1966 has been a staff Pathologist and Blood Bank Medical Director at Tampa General Hospital and the University Community Hospital, Tampa. He is an Associate Clinical Professor of Pathology at the University of South Florida College of Medicine and Immediate Past President of the Florida Association of Blood Banks.

Secretary of the young organization and continued until her retirement in May, 1976. She remains a consultant to FABB.

The FABB and the AABB are similar in that only institutional members may vote. Institutional membership is limited to those hospitals and blood banks meeting strict requirements of standards, inspection and accreditation, and more recently, a voluntary donor population and fiscal responsibility. The individual membership group includes an interesting and diverse mixture of physicians, technologists, nurses, researchers, donor recruiters and the usual managerial categories such as those from Accounting, Data Processing, Purchasing, Personnel, etc. The AABB has governance by a Board of Directors representing districts without representation by constituent state association.

In 1951 California established a state clearinghouse for exchange of replacement credits and to help shortages and excesses. A Florida clearinghouse was developed in 1953. This was absorbed into a nationwide AABB system in 1956 as the Southeast District Clearinghouse of AABB.

The American National Red Cross was founded in 1881 to "mitigate the horrors of war, but it has officially extended its labors to fields of famine and pestilence and disaster by flood and fire."[1] The Red Cross Board of Governors made an overt decision at the end of World War II to form its National Blood Program to collect blood for the civilian population whereas previously blood had been collected for military use.

The only Red Cross unit in Florida is at Daytona Beach and supplies services for Volusia County. All of the other community blood banks and the hospital blood banks in Florida are members of FABB and AABB. The state has enjoyed an adequate supply of blood and components during the time that blood banking has been a medical reality. All of the blood banks have exclusively voluntary donors except for the John Elliot Blood Bank in south Florida.

Both Red Cross and AABB (and FABB) are non-profit organizations dedicated to adequate supplies of safe, voluntarily donated blood. There are, however, deep differences in recruitment philosophy. Red Cross has stated that only the community responsibility concept should be used for recruitment. Under this concept persons in the community should donate blood which would be available at the same cost to all persons, whether or not they had been a donor. The AABB feels that there must be "pluralism" with either community responsibility or individual responsibility or a combination of both concepts used by a blood bank in order to insure adequate blood supplies. In individual responsibility a donor who later needed blood, or a patient who had family or friends to replace blood would receive blood at a lower cost than a non-donor, thereby encouraging donations by individuals.

Most Florida blood banks use a combination of these concepts with a refundable Replacement Deposit Fee (Non-Replacement Fee) for individuals and with group accounts for churches, clubs, industrial groups, labor unions, etc. or persons motivated to donate for the "community." In July, 1978, the American Red Cross and Florida AFL-CIO signed a "statement of understanding"[3] and during the 1979 Florida Legislative Session, the Daytona Red Cross and AFL-CIO teamed up in an attempt to make Replacement Deposit illegal.[2] Vigorous lobbying by a large number of Florida blood bankers prevented passage of the legislation.

The identifiable factors leading to the National Blood Policy began in February, 1971 when the National AFL-CIO Executive Council at its Bal Harbor meeting endorsed a plan for a single national blood program controlled by the Red Cross. On March 2, 1971 the Red Cross presented a national "action plan" which would extend Red Cross donor recruitment into areas served by AABB facilities. This was rejected by AABB, whose president pointed out "increasingly blatant attempts of this organization (Red Cross) to dominate" and "apparent kinship between the Community Service Division of the AFL-CIO and top echelon Red Cross paid staff."

Also in a 1971 book, *The Gift Relationship: From Human Blood to Social Policy,*[4] by English economist R. M. Titmus and in an NBC News Special in the "Chronologue" series, the American blood picture was presented in an unfavorable light to wide audiences.

Congressional Legislative activity and the Department of HEW planning conferences in late 1971 and 1972 resulted in the National Blood Policy. On July 10, 1973, Caspar Weinberger, then Secretary of HEW, enunciated to science reporters, and ultimately to the nation, the national goals for adequate blood supply (quantity), quality (voluntary donors), accessibility (cost) and efficiency (low out-date rate).

Under implied threat of legislative remedy, Red Cross, AABB and the Council of Community Blood Centers (a group of large urban community banks with the community responsibility concept) under the aegis of the AMA formed the American Blood Commission. At its inaugural meeting on April 4, 1975, a Board having the now familiar mix of providers and consumers was installed.

The ABC set up eleven task forces. Only four have been active. These are the task forces for donor recruitment, commonality in automation (labels), blood data, and regionalization. The regionalization task force elected to avoid arbitrarily cutting up the country into geographic regions but opted to set up a mechanism for recognizing locally determined Regional Associations of Blood Service Units. The ABC recognition guidelines indicate criteria for performance (such as total supply,

etc.) and for governance (such as a broad base of providers and consumers). In March, 1979 ABC recognized ten regional associations from around the nation. All of these consisted of essentially a blood drawing center and its associated transfusion units. The FABB, feeling that generally its member banks have good rapport with each other and having pre-existing district divisions, applied in 1977 to ABC for recognition as a region. The original Ad Hoc Committee was led by Sanford A. Mullen, M.D. of Jacksonville and included FABB members and representatives of Red Cross, American Cancer Society, Florida Hospital Association, Blue Cross/Blue Shield, AABB Southeastern District Clearinghouse, AFL-CIO, and Florida State Chamber of Commerce. The Ad Hoc Committee was fortunate to have as one of its members, Paul J. Schmidt, M.D. of Tampa who also was a member of the recognition subcommittee of the ABC Regionalization Task Force.

The Florida Committee decided that a separately chartered Florida Regional Association of Blood Service Units could best fulfil the ABC criteria. Operationally, the Association would enhance inventory utilization efficiency by using a reporting system and transfer of blood, components and credits through the AABB Southeast District Clearinghouse located in Jacksonville. It would enhance donor recruitment through a statewide donor recruitment committee and recruitment programs compatible with both individual and community responsibility banks.

For two years the Committee, subsequently chaired by Edward O. Carr, MT (ASCP) SBB, managing Director of Central Florida Blood Bank, labored to produce a charter which could accommodate AABB members, Daytona Beach Red Cross and John Elliot Blood Bank, which had converted to community responsibility concept in October, 1978. The Articles of Association of the Florida Regional Association of Blood Service Units were to have been signed at an Inaugural Convention on May 20, 1979 at Tampa. The articles had been presented on February 24, 1979 to the FMA Council on Speciality Medicine which recommended that FMA become a member of the FRABSU. The interests of FMA on the FRABSU Governing Council will be represented by a FMA member who also represents FABB. Also in February, however, the Daytona Beach Red Cross was instructed by the Red Cross National Vice-President not to participate in the Florida Association. AFL-CIO also ceased participation in meetings as did the John Elliot Blood Bank. John Elliot has subsequently applied to ABC for recognition as a region for the south Florida area that it serves.

So, FABB, having been recognized as a blood banking pioneer in the truest sense of the term, will alter the articles to fit the withdrawal of the above mentioned organizations leaving a program which does, however, meet the blood needs of the major portion of the state. If the original plan, including Red Cross and John Elliot, had been fulfilled, it would have been a unique Regional Association indeed, since both community responsibility and individual responsibility blood collecting facilities would be sharing inventory through the same organization with allegiances to the people they serve overshadowing allegiances to national organizations.

References are available from the author upon request.

• Dr. Hooper, 3100 East Fletcher Avenue, Tampa 33612.

Florida Blood Banks Accredited by the Florida Association of Blood Banks (Institutional Members of FABB)

NAME	LOCATION	MEDICAL DIRECTOR
Bay Mem. Med. Ct. Blood Bank	Panama City, 600 N. McArthur Avenue, 32401	William A. Sybers, M.D.
*Broward Community Blood Center	Ft. Lauderdale, 17 S.E. 3rd Ave., 33301	Russell S. Jones, M.D.
Broward Gen. Med. Ct. Blood Bank	Ft. Lauderdale, 1600 S. Andrews, 33316	R.J. Poppiti, M.D.
Calhoun Gen. Hosp. Blood Bank	Blountstown, 424 Burns Ave., 32424	E.B. White, M.D.
*Central Florida Blood Bank, Inc.	Orlando, 1300 S. Kuhl Ave., 32806	Oscar W. Freeman, M.D.
*Civitan Regional Blood Center, Inc.	Gainesville, 1330 N. W. 13th St.	Douglas Shanklin, M.D.
Community Hosp. of New Port Richey BB	New Port Richey, 205 High St., 33552	Paul G. Winquist, M.D.
*Community Blood Bank, Inc.	St. Petersburg, 626 Sixth Ave., S., 33701	Ira C. Evans, M.D.
*Edison Regional Blood Center	Ft. Myers, 1947 Colonial Blvd., 33901	Robert B. Schultz, M.D.
Doctors Hospital Blood Bank	Coral Gables, 5000 University Dr., 33134	Maxwell M. Sayett, M.D.
Everglades Hospital Blood Bank	Pahokee, 200 S. Barfield Hwy., 33476	Leon W. Powell, M.D.
Glades Gen. Hosp. Blood Bank	Belle Glade, 1201 South Main Street, 33430	Mario S. Ramos, M.D.
Hardee Memorial Hosp. Blood Bank	Wauchula, P.O. Box 1058, 33873	L. Weerasooriya, M.D.
Highlands Gen. Hosp. Blood Bank	Sebring, 3600 S. Highlands Ave., 33870	Roberto A. Caso, M.D.
Holmes, J. E. Reg. Med. Ct. Bl. Bk.	Melbourne, 1350 S. Hickory, 32901	L. E. McHenry, Jr., M.D.
Holy Cross Hosp. Blood Bank	Ft. Lauderdale, P.O. Box 23460, 33307	Anthony R. Clerch, M.D.
*Hunter Blood Center	Clearwater, 402 Jefford, 33516	James B. Leonard, M.D.
Imperial Point Hosp. Blood Bank	Ft. Lauderdale, 6401 N. Federal Hwy., 33308	Russell S. Jones, M.D.
*Indian River Blood Bank, Inc.	Vero Beach, P.O. Box 1494, 32960	H. L. Schofield, M.D.
Jackson Mem. Hosp. Blood Bank	Dade City, 608 W. Howard Ave., 33525	Edward B. Smith, M.D.
*Jacksonville Blood Bank, Inc.	Jacksonville, P.O. Box 2758, 32203	Sanford A. Mullen, M.D.
*John Elliott Mem. Bl. Bk. of Dade Cty.	Miami, P.O. Box 420100, 33142	Thomas B. Turner, M.D.
Lake Shore Hospital Blood Bank	Lake City, P.O. Box 1989, 32055	J.J. Goyenechea, M.D.
Lake Wales Hospital Blood Bank	Lake Wales, P.O. Box 391, 33853	David J. Cox, M.D.
Lawnwood Med. Ct. Blood Bank	Ft. Pierce, P.O. Box 188, 33450	R. C. Iniquez, M.D.
Lee Mem. Hosp. Blood Bank	Ft. Myers, P.O. Drawer 2218, 33902	R. Peter Rosier, M.D.
Lehigh Acres Gen. Hosp. Blood Bank	Lehigh Acres, 1500 Lee Blvd., 33936	R. Peter Rosier, M.D.
*Leon County Blood Bank, Inc.	Tallahassee, 1240 Hodges Dr., 32303	Clarence W. Ketchum, M.D.
*Lower West Coast Blood Bank	Sarasota, 1875 Arlington Street, 33579	J. Robert Spencer, M.D.
Lykes Mem. Hosp. Blood Bank	Brooksville, 1100 S. State Road 700, 33512	William J. Winter, M.D.
Nassau Gen. Hosp. Blood Bank	Fernandina Beach, 1700 E. Lime St., 32034	Farid Ullah, M.D.
*Northwest Florida Blood Center	Pensacola, 2201 North 9th Avenue, 32503	Gerard H. Hilbert, M.D.
Madison County Mem. Hosp. Blood Bank	Madison, 201 E. Madison St., 32340	W. J. Bibb, M.D.
*Manatee County Blood Bank, Inc.	Bradenton, 216 Manatee Ave., East, 33508	Kenneth L. Schermer, M.D.
*Marion County Blood Bank, Inc.	Ocala, 1051 S. W. 1st Street, 32670	William C. Butscher, M.D.
Medical Center Hosp. Blood Bank	Punta Gorda, 809 East Marion Ave., 33950	Donald L. Horn, M.D.
Memorial Hosp. Blood Bank	Hollywood, 3501 Johnson St., 33021	C.J. Flanagan, M.D.
Mount Sinai Hosp. Blood Bank	Miami Beach, 4300 Alton Road, 33140	Jack Lubin, M.D.
Naples Community Hosp. Blood Bank	Naples, 350 Seventh St., North, 33940	H. O. E. Schmid, M.D.
North Broward Hosp. Blood Bank	Pompano Beach, 301 Sample Road, 33064	Gustav J. Selbach, M.D.
Naval Regional Medical Center	Jacksonville, 32214	Daniel B. Lestage, M.D.
Naval Regional Medical Center	Orlando, 32813	Antonio A. Tamara, M.D.
Naval Regional Medical Center	Pensacola, 32512	David F. Garvin, M.D.
*Palm Beach Blood Bank, Inc.	West Palm Beach, P.O. Box 8237, 33407	V.M. Johnson, M.D.
Polk Gen. Hosp. Blood Bank	Bartow, P.O. Box 60, 33830	D. Richard Jones, M.D.
*Putnam County Blood Bank, Inc.	Palatka, 2919 Kennedy Road, 32077	Claude M. Knight, M.D.
St. Anthony's Hosp. Blood Bank	St. Petersburg, 600 12th St., N., 33705	Leo E. Reilly, M.D.
*St. John's County Blood Bank, Inc.	St. Augustine, Civic Center Bldg., 32084	Hardgrove S. Norris, M.D.
St. Joseph's Hosp. Blood Bank	Port Charlotte, 601 N. E. Harbor Blvd., 33950	H. Ivan Brown, M.D.

*—Community Blood Banks

NAME	LOCATION	MEDICAL DIRECTORS
Shands Teach. Hosp. Blood Bank	Gainesville, Archer Road, 32610	Douglas Shanklin, M.D. (A. Dir.)
South Florida Bapt. Hosp. Blood Bk.	Plant City, Drawer H., 33566	J.A. Cima Franca
*Southwest Florida Blood Bank, Inc.	Tampa, P.O. Box 2125, 33601	Paul J. Schmidt, M.D.
Suwanee County Hosp. Blood Bank	Live Oak, 5th Ave. & Seriven St., 32060	Nelson A. Murray, M.D.
*R.P. Tew Mem. Blood Center	Lakeland, 1315 N. Florida Ave., 33801	D. Richard Jones, M.D.
Thomas, John Henry, Mem. Blood Bank	Gainesville, 912 S. W. 4th Ave., 32601	George E. Byers, Jr., M.D.
U.S.A.F. Regional Hosp. Blood Bank	MacDill AFB, 33608	Roy A. Hemelt, M.D.
U.S.A.F. Regional Hosp. Blood Bank	Tyndall AFB, 32401	Charles R. Bost, M.D.
University Community Hosp. Blood Bank	Tampa, 3100 E. Fletcher Ave., 33612	Glenn S. Hooper, M.D.
Venice Hospital Blood Bank	Venice, P.O. Box 967, 33595	Charles E. Johnson, M.D.
V.A. Hospital Blood Bank	Tampa, 13000 N. 30th St., 33612	Edward L. Lee, M.D. (Act. Dir.)
Walker Mem. Hosp. Blood Bank	Avon Park, Box A, 33825	Roberto A. Caso, M.D.
Winter Haven Hosp. Blood Bank	Winter Haven, 200 Avenue F., N. E., 33880	David J. Cox, M.D.
Washington County Hosp. Blood Bank	Chipley, 301 South Blvd., 32428	Gene Morton, M.D.
L. W. Blake Mem. Hosp. Transf. Ser.	Bradenton, Fla., 2020 59th St., W., 33505	John D. Lehman, M.D.
Baptist Med. Ct. Transfusion Ser.	Jacksonville, 800 Prudential Dr., 32207	Aftab Khan, M.D.
Bayfront Med. Center Trans. Ser.	St. Petersburg, 701 6th Ave., S., 33701	Larry J. Davis, M.D.
Bethesda Mem. Hosp. Trans. Service	Boynton Beach, 2815 Seacrest Blvd., 33435	Babino S. Cuevas, M.D.
Bradford County Trans. Service	Starke, 922 E. Call St., 32091	C. E. Hermandez, M.D.
Cedars of Lebanon Hosp. Trans. Ser.	Miami, 1400 N. W. 12th Ave. 33136	Daniel Seckinger, M.D.
Clay County Mem. Hosp. Trans. Ser.	Green Cove Springs, P.O. Box 808, 32043	M. A. Mulford, M.D.
Coral Gables Hosp. Trans. Ser.	Coral Gables, 3100 Douglas Road, 33134	Sean Kaufman, M.D.
Coral Reef Gen. Hosp. Trans. Ser.	Miami, 9333 Southwest 152nd St., 33157	E. L. Cortinas, M.D.
Cypress Community Hosp. Trans. Ser.	Pompano Beach, 600 S. W. 3rd Street, 33441	Marvin A. Berkowitz, M.D.
Fawcett Mem. Hosp. Trans. Ser.	Port Charlotte, 101 N. W. Olean Blvd., 33952	R. H. Imami, M.D.
Fishermen's Hosp. Trans. Ser.	Marathon, 3301 Overseas Highway, 33050	A. J. Fernandez, M.D.
Florida Hosp. Transfusion Ser.	Orlando, 601 E. Rollins Ave., 32803	Rodney Holcomb, M.D.
Florida Keys Mem. Hosp. Trans. Ser.	Key West, Stock Island, 33040	A. J. Fernandez, M.D.
Ft. Myers Community Hosp. Trans. Ser.	Ft. Myers, 3785 Evans Ave., 33901	Wallace H. Graves, M.D.
Hendry Gen. Hosp. Trans. Ser.	Clewiston, 524 W. Sagamore, 33440	Wallace H. Graves, M.D.
Hialeah Hosp. Transfusion Service	Hialeah, 651 East 25th St., 33013	
Hollywood Med. Center Trans. Ser	Hollywood, 3600 Washington St., 33021	Donald Zeller, M.D.
Jackson Hosp. Transfusion Service	Marianna, P.O. Box 940, 32446	James T. Cook, M.D.
John F. Kennedy Mem. Hosp. Trans. Ser.	Lake Worth, P.O. Box 1489, 33460	Norman C. Sudduth, M.D.
Lake Community Hosp. Transfusion Ser.	Leesburg, 700 North Palmetto St., 32748	William H. Shutze, M.D.
Leesburg Gen. Hosp. Transfusion Ser.	Leesburg, 600 E. Dixie Ave., 32748	William H. Shutze, M.D.
Martin Mem. Hosp. Trans. Service	Stuart, P.O. Box 2396, 33494	Leon W. Powell, M.D.
Mease Hosp. Transfusion Service	Dunedin, 834 Milwaukee Ave., 33528	Fred Ionata, M.D.
Memorial Hosp. of Jacksonville T.S.	Jacksonville, 3625 University Blvd., S., 32216	George M. Katibah, M.D.
North Florida Regional Hosp. T.S.	Gainesville, State Road 26 at I-75, 32604	Douglas R. Shanklin, M.D.
Orlando Gen. Hosp. Transfusion Serv.	Orlando, 7727 Lake Underhill Dr., 32807	
Palm Springs Gen. Hosp. Trans. Ser.	Hialeah, 1475 W. 49th St., 33015	Michael Felder, M.D.
South Lake Mem. Hosp. Trans. Ser.	Clermont, 847 8th St., 32711	W. H. Schrader, M.D.
South Miami Hosp. Transfusion Ser.	South Miami, 7400 S. W. 62nd. Ave., 33143	F. Lynn Leverett, M.D.
St. Mary's Hosp. Transfusion Service	West Palm Beach, 900 49th St., 33407	Jackson L. Thatcher, M.D.
Tarpon Springs Gen. Hosp. Trans. Ser.	Tarpon Springs, 1395 S. Pinellas Ave., 33589	Donald L. Howie, M.D.
Victoria Hosp. Transfusion Service	Miami, 955 N. W. 3rd St., 33128	G.A. Puente-Duany, M.D.
West Pasco Hosp. Transfusion Ser.	New Port Richey, 500 Indiana Ave., 33552	Frank C. Coleman, M.D.
West Volusia Mem. Hosp. Trans. Ser.	DeLand, 701 West Plymouth, 32720	John P. Kalas, M.D.
Jackson Mem. Hosp. Trans. Service	Miami, 1611 N. W. 12th Ave., 33136	Thomas A. Noto, M.D.

Associate Members
Florida Association of Blood Banks

Beaches Hospital	Jacksonville Beach, 1430 16th Ave., South, 32250
Community Hospital	Kissimmee, P.O. Box 998, 32741
Halifax District Hospital	Daytona Beach, P.O. Box 1990, 32015
Hope Haven Children's Hospital	Jacksonville, 5720 Atlantic Blvd., 32207
Mercy Hospital	Miami, 3663 South Miami Ave., 33133
North Shore Hospital, Inc.	Miami, 9200 N. W. 11th Ave., 33150
Riverside Hospital	Jacksonville, 2033 Riverside Ave., 32204
St. Francis Hospital	Miami Beach, 250 West 63rd Street, 33141
St. Vincent's Hospital	Jacksonville, Barrs & St. Johns Ave., 32204
University Hospital	Jacksonville, 655 West 8th St., 32209

Transfusion Mortality; With Special Reference to Surgical and Intensive Care Facilities

Paul J. Schmidt, M.D.

Abstract: Federal regulations require the reporting of any fatal complication of blood transfusion. The law has not resulted in the reporting of posttransfusion hepatitis but deaths due to transfusion accidents are being recorded at a rate of one per million transfusion. All of 22 preventable primary fatalities described for the years 1976 to 1978 were due to clerical errors resulting in a mismatch in the significant ABO groups. Seventeen of those deaths were the result of a transfusion given to the wrong patient, usually in a surgical or intensive care facility, when established identification procedures were not followed.

Death directly caused by adverse reaction to blood transfusion is now a rare event. When it does occur, it creates serious medical-legal problems. As a result, the modern medical literature is bare of descriptions of the event and carries no suggestion of its incidence. In December of 1975 it became mandatory to report immediately to the Food and Drug Administration (FDA) "when a complication of blood collection or transfusion is confirmed to be fatal" in the United States.[1]



Dr. Schmidt

The Author

PAUL SCHMIDT, M.D.

Dr. Schmidt is Director of the Southwest Florida Blood Bonk in Tompa. Before coming to Florido in 1974, he was Director of the Blood Bank at the National Institutes of Heolth for 20 years ond was the Federol Government's senior odvisor on blood bonking. The outhor is Clinical Professor of Pothology at the University of South Florido College of Medicine, a member of the Stondords Committee of the Americon Association of Blood Banks, and President-Elect of the Florido Association of Blood Bonks. One of his hobbies is the history of medicine ond he has written extensively on thot subject. He has o collection of eorly books and instruments reloting to the history of tronsfusion in this country.

The information collected by law is available to a questioner under the Freedom of Information Act. I requested and obtained all of the reports to the FDA on fatal transfusion reactions for 1976, 1977, and 1978. That information was supplied to me by photocopies of the raw reports. Only the information which would serve to identify the blood bank, the hospital and the participants had been deleted from those reports.

Since the informants had no standard reporting method, and were more interested in their legal involvement than in giving scientific data, most of their reports were brief. Nevertheless, they supply the richest modern mine of information on the mortality from transfusion.

The analysis of those raw reports which follows is totally mine and in no way should reflect on the FDA. That agency gave the information only because it had to under the Freedom of Information of Act.

Results

Reports were made to the FDA on a total of 69 deaths for the whole country in the first three years after the Regulation was issued. The classification chosen for the interpretation used in the Table is explained as follows:

Incidental—Nine Cases

When it seemed to me that, although there was a transfusion mishap, the patient would have died even if not transfused, the cases were called incidental and not

Cause of 69 Deaths Related to Transfusion

9	Incidental
60	Related
21	Contributory
39	Primary
8	Hepatitis
2	Respiratory
1	Heated Blood
1	Bacterial Contamination
1	Graft vs. Host Disease
1	Undetermined
25	Red Cell Destruction
2	Delayed, Anamnestic (Rh)
1	Hemolytic, non-immunological
22	ABO Incompability
0	Technical Problems
22	Clerical Errors
5	Laboratory
17	Wrong Recipient

analyzed further. Some verbatim examples from the reports were:

"But the blood was given to Mr. K.R. who has already received thirty-two units in surgery. The patient died the following day with massive gunshot wounds to the lungs and liver."

"The patient had an allergic reaction which could have been caused by anesthetic agent or blood. There was no evidence of a hemolytic transfusion reaction. The patient developed DIC for an unknown reason."

Contributory—Twenty-one cases

Transfusion was considered to be a contributory cause of death when it seemed the patient could have survived if the benefit of transfusion had been received rather than the added insult of a transfusion mishap. Some examples would be:

Group O patient was given 125 ml of group A red cells. Four days later the patient died "of sepsis and the autopsy showed bilateral pneumonia and pleural effusions with severe generalized atherosclerosis with previous myocardial infarctions and arterial and arteriolar nephrosclerosis."

In another group O patient: "I do not feel it is clear as to what part the incompatible type A blood played in the demise of the patient. I report it because it is apparent that it had an adverse effect, if for no other reason than delaying surgery and it was associated with the ultimate death in the patient."

Primary—Thirty-nine cases

Transfusion was accepted as being the primary cause of death when the patient died as a direct result of transfusion. In 14 of those cases as are listed in the Table, the events were not erythrocyte antigen-antibody incompatibility but rather diseased blood, too much blood, or abused blood. In one unusual case a patient received 50 ml of blood when he had an adverse reaction which "continued to worsen." He was transferred to another hospital and died six days after transfusion. It is not clear how "the element of human error which occurred in this instance" was fatal.

Finally, there are the 25 cases due to problems of red cell destruction. Two of them were not preventable but rather were due to anamnestic antibody responses.[2] In one patient there were acute respiratory and renal problems with hemoglobinuria beginning twelve hours later, and death. No serological or bacteriological problem was shown. There were thus 22 cases for final analysis as classical cases of donor-patient red cell incompatibility. All of those 22 cases were due to problems of ABO mismatch. In all cases it was a *clerical identity error* and never a technical failure of the test systems designed to pick up a weak blood group or hidden antigens. In some cases the clerical error occurred in the laboratory but in most, i.e. 17, it was a *case of proper preparation of the right blood being given to the wrong patient.*

In five of those cases the details under which the identification of the patient was missed were not given. In *all* 12 of the others, the patient was in the intensive care or surgical suite.

A sad litany of excerpts from the verbatim reports of solo, duo and trio failures is as follows:

"The two units of AB blood were then left in the operating room and transfused to the next patient, who was a group O, without performing the proper identification between the patient and the units of blood."

"The transfusion occurred in an operating room when operating room personnel pulled a unit of blood designated and appropriately marked for a different patient with the same last name as the deceased patient."

"Almost 2 units of Group A cells were transfused to a Group B patient, by the anesthesiologist who checked blood types and unit numbers, but not the name of the patient."

"The pump technician, believing the blood to have been properly checked, used it to prime the pump and it was thereafter administered to the patient when bypass was initiated. There is no evidence that it was in fact actually checked by anyone."

"The nurse failed to check the patient's wristband against the identification on the blood and gave patient Y's packed cells to patient X. Patient Y was B positive and patient X was O positive."

"The patient's name was not verified either verbally

or by checking the wristband."

"In this case the Anesthesiologist went to the refrigerator and obtained two units of blood that he assumed were for his patient who was O Neg. He checked unit numbers, but failed to check name and apparently type of blood. He also failed to review with another person the data and proceded to transfuse both units to the patient. One unit was O Neg, and the other (clearly labeled A Pos for a different patient) was A Pos."

"Operating room personnel had brought the blood from the Blood Bank to the O.R. Suite, and a nurse mistakenly thought the blood was intended for this patient. This was not checked by the nurse who brought the units to the room, nor by the anesthesiologist who administered the two units."

"Unfortunately, a second Registered Nurse in the process of hanging up the bloods switched the two bags, so that patient O received A blood and patient A received O blood."

"This unit was in the operating room blood refrigerator and was improperly identified by the nurse anesthetist and nurse who checked the unit. A thorough review of blood identification procedures has been conducted and it appears that the error was due to simply not following the appropriate procedure as written in the nursing service manual."

"When blood was requested by the anesthesia service for Mrs. R., a circulating nurse went to the blood refrigerator and removed a unit of Mrs. Y.'s blood which was Group A Rho (D) positive from the refrigerator. This was taken to the O.R. where the nurse-anesthetist handling Mrs. R's case hung this unit without confirming with either the circulating nurse or the other nurse-anesthetist in the room the name or identification numbers of the patient."

Discussion

There are obvious shortcomings to the data collected and they do not report on the most frequent cause of death after transfusion, i.e. hepatitis. The federal reporting regulation is probably ambiguous in regard to posttransfusion hepatitis. Hepatitis deaths are not being reported to the FDA, although hepatitis is a "reportable disease" for the Center of Disease Control. But perhaps the FDA does not want hepatitis reported to it since transfusion deaths are to be reported "by the facility that performs the compatibility tests in the event of a transfusion reaction."[1] Some blood products that can cause hepatitis do not require a compatibility test before transfusion e.g. plasma, platelets. Is hepatitis a "transfusion reaction?" Who is to report such a death when it takes place a year or more after transfusion?

These data describe one avoidable death per million transfusions. Acute renal failure and disseminated intravascular coagulation per se were not stressed in the raw reports. The impression was rather of death due to uncontrollable hypotension and shock. The deaths were mostly due to the transfusion of group A blood or red cells to a group O recipient because of clerical error. The level of routine competence in this country seems to have easily overcome the technical difficulties of ensuring compatible blood and of managing most complications so that they do not become fatalities. *What has not been eliminated is simple clerical error.*[3] In one large surgical situation,[4] where no simple transfusion accidents have been seen since 1964, the Blood Bank staffs a distribution point *inside* the surgical suite.

The laboratory should never overdo technical detail to the detriment of rapid and inexpensive performance.[5] However, it should be remembered that the goal of transfusion is more than just the avoidance of mortality. There should be no mortality and no morbidity, but even more, a good result should be effected by the proper and skillful use of a knowledge of the available modes of therapy.

Nevertheless, looking at only the raw data on mortality, the problem remains one of giving the right blood to the wrong patient. In this series, it was the patient who was unconscious, and who did not even have the transient security of identification by hospital bed, who was killed by the forgetful, the inadequate and the careless. There were some surgeon's helpers who did not help the patient.

Editor's Note—It is the feeling of the editors that every surgeon should not only read this article but take its message to heart, and also take it to his entire nursing and office staff and operating room staffs and require them to read this article. The message is simple, straight forward, and undeniably true.

References are available from the author upon request.

• Dr. Schmidt, P.O. Box 2125, Tampa 33601.

Bloodletting—Resurrection of an Old Medical Practice (A Discussion of Therapeutic Pheresis)

F. Lynn Leverett, M.D.

Abstract: Cyto—and plasmapheresis has been made possible with the development of automated cell separators. A total of 349 pheresis procedures using the Haemonetics Model 30 Cell Separator have been performed in a 16 month period at our 400-bed community hospital. Of these, 113, or one-third, have been therapeutic phereses. The advent of this "new" modality of treatment has produced some exciting results and has led to a new and intimate role for the pathologist in the health care team.

Bloodletting, through cyto- and/or plasmapheresis, is again in vogue in the medical community. Now, however, the techniques are sophisticated and are supported by knowledge of the disease processes. Using a mechanical cell separator, specific blood components can be removed from a healthy donor, concentrated and transfused to a patient in need. On the other hand, in disorders where cellular or liquid blood components are in excess, or are deleterious, they can be selectively removed from the patient, not infrequently with dramatic improvement.

The principals of cell separation are straightforward. Whole blood is drawn from the donor (much as in a regular blood donation), anticoagulant added to the drawing line immediately, and delivered into a sterile centrifuge bowl. As the bowl spins, the incoming blood separates according to density differences-red cells on the bottom, platelets and white cells at the interface and plasma on the top. As the blood continues to flow into the bottom of the sterile spinning bowl, the plasma is forced upward and out into a sterile collection bag. When the plasma layer is drawn off, the platelet-rich plasma outflow can then be diverted into another sterile collection bag. This layer is then followed by the leukocyte-rich red cell interface which can be collected with the platelets or diverted into a third collection bag. When the platelet and/or WBC collection is complete, the blood flow from the donor is stopped, as is the centrifuge bowl. The drawing line is kept open with a saline drip. The plasma is returned to the red cells and both reinfused to the donor usually through a return line in the other arm, although the drawing line can be used for reinfusion. The process can be repeated many times enabling a rich harvest of granulocytes and/or platelets. The initial development and still the major use of cell separators is for leukopheresis and/or plateletpheresis of healthy, normal donors as just described.

The "donor" and "collection" system can be manipulated in many ways to achieve the desired result. The most exciting applications of these versatile instruments has been in the realm of therapeutic pheresis. Therapeutic pheresis can best be thought of as component pheresis. That portion of the blood or substance in the blood causing the damage to the patient can be mechanically removed.

Examples of diseases treated by plasmapheresis are listed in Table 1. Examples of diseases treated by cytopheresis are given in Table 2. Our experience with

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therapeutic pheresis during a 16 month period is shown in Table 3.

Though the plasma removal procedure is commonly referred to as plasmapheresis, with few exceptions, what is done is plasma *exchange*. The patient's plasma containing the damaging agent, i.e., autoantibody, immune complexes, toxins, etc., is removed, but is replaced, volume for volume, with physiologic fluids. The choice of replacement fluids is determined by a number of factors: the patient's clinical status, the cost of the fluids, the risk of hepatitis, the amount of plasma being removed and the need for maintenance of normal coagulability.

Generally, we use approximately equal amounts of saline, dextran and plasma protein fraction (the PPF is administered last so it will not be exchanged and lost). Our choice is dictated by a desire to keep cost and hepatitis exposure at a minimum. In some of our severely hypoproteinemic patients (3.0 gm/dl total protein or less) we have elected to use PPF exclusively. In some severely anemic patients, we have administered whole blood as the last 500 ml or 1,000 ml of replacement fluid.

The success of our pheresis therapy has varied, and for the most part has depended on the disease and the extent of its damage at the time pheresis was begun. Most of these patients have been treated with immunosuppressive and lymphotoxic agents without success. Particularly in the autoimmune disorders intensive plasma exchange brings about the removal of circulating antibody, and subsequently, tissue bound antibody or immune complexes. It is thought that the immune system recognizes the decreased antibody levels and responds by increased production of the aberrant clones of lymphocytes. The administration of cytotoxic drugs during this period of intense proliferation maximizes the effect of the cytotoxic agents. Plasma exchange is a new and valuable therapeutic modality in the treatment of autoimmune diseases.

Though space does not allow an in-depth discussion of all of these cases, several are worthy of comment.

Our first therapeutic procedure (in fact our very first procedure with the cell separator!) was in a patient who had had myasthenia gravis for 25 years. At the time, the patient had been hospitalized for 6 months, had been on a respirator the entire time, was bedfast, required mechanical suction of secretions, could eat only pureed foods and had not responded to the accepted therapeutic regimens. Plasma exchanges were begun on May 4, 1978, and after 8 exchanges, the patient was discharged June 10, 1978, eating solid foods, walking freely, and totally independent of mechanical respirators. She has remained on a chronic exchange program as an outpatient. Initially after discharge, exchanges were on a weekly basis with continued improvement in strength. As

Table 1—Diseases Treated by Plasmapheresis

A. Autoimmune Diseases

1. Myasthenia Gravis
2. Goodpasture's Syndrome
3. Systemic Lupus Erythematosus
4. Rheumatoid Arthritis
5. Pemphigus Vulgaris
6. ITP (Idiopathic Thrombocytopenic Purpura)
7. Polymyositis
8. Multiple Sclerosis
9. Autoimmune Hemolytic Anemia

B. Immune-Mediated Diseases

1. Rh Disease (Mother)
2. Acquired-Anti-Factor VIII

C. Non-Immune (Or Questionable Etiology)

1. Hyperviscosity Syndrome
2. Thrombotic Thrombocytopenic Purpura
3. Drug Overdose
4. Fulminant Hepatitis with Liver Failure
5. Coagulation Inhibitors
6. Intractable Congestive Heart Failure
7. Familial Hypercholesterolemia.

Table 2.—Diseases Treated by Cytopheresis

A. White Cells

1. Leukemia-Acute and Chronic
2. Lymphopheresis (Generally in conjunction with plasmapheresis in treatment of an autoimmune disease.)
3. Cutaneous T-cell Lymphoma

B. Platelets-Thrombocytosis

C. Red Cells

1. Sickle Cell Anemia
2. Polycythemia, 1° or 2°
3. Paroxysmal Nocturnal Hemoglobinuria

Table 3.—Therapeutic Pheresis At South Miami Hospital

May 1978 to September 1979

Disease	Number Of Patients	Number Of Procedures
Myasthenia Gravis	3	79
Thrombotic Thrombocytopenic Purpura	1	3
Hyperviscosity Syndrome	1	1
Goodpasture's Syndrome	1	1
Chronic Lymphocytic Leukemia	1	6
Systemic Lupus Erythematosis (with rapidly progressive glomerulonephritis)	2	21
Intractable Congestive Heart Failure	1	2

improvement plateaued, the exchanges were decreased to 2 week, 3 week and, at times, 4 week intervals as she required. Even though muscle strength drops off between exchanges, the patient "feels better than anytime in the last 20 years." In April of 1979 she "took and passed my restricted driver's test-after standing in line for 40 minutes!"

The other two myasthenics were considerably less severe and their primary difficulties were fatiguability and visual problems due to extraocular muscle weakness. One patient elected to discontinue the program after one procedure due to the expense and time commitment. He was an active, self-employed, uninsured, construction worker. Our other patient was begun on the exchange program in an attempt to lower her high steroid requirement. We were able to decrease her Prednisone from 60 mg qd to 15 mg qod at an improved level of function. However the patient decided "it wasn't doing her much good," began to skip appointments and eventually stopped coming after a total of 27 exchanges.

Goodpasture's Syndrome,* in which antibodies to glomerular and alveolar basement membranes frequently cause fatal glomerulonephritis and hemorrhagic pneumonitis, is the disease in which plasma exchange has been most consistently beneficial—if instituted prior to the development of anuria. In our single case, the patient had been anuric for days and had extensive bilateral pneumonitis at the time that a four liter plasma exchange was done. She died within twelve hours and autopsy revealed lungs, 1.5 K each, entirely consolidated by hemorrhagic pneumonitis.

A combination of plasmapheresis and plasma exchange was used to treat a patient with hyperviscosity syndrome due to Waldenstrom's macroglobulinemia. He presented with anemia, a bleeding diathesis and congestive heart failure. His expected plasma volume was 2.6 liters; actual plasma volume was 4.9 liters. Normal plasma viscosity, as measured in our laboratory, is 1.6 and this patient's viscosity was 12.6. In our pheresis-exchange procedure we removed 4.0 L of plasma, while our fluid return was 1.0 L of 1/2NS, 1.5 L of Ringer's lactate and 0.5 L of ACD (anticoagulant). The patient's plasma viscosity post-exchange was 5.3 and 48 hours after the exchange was 2.2. The procedure, supplemented with infusion of packed red cells, was successful in alleviating the platelet dysfunction and congestive heart failure. Hyperviscosity has always been treated by "bloodletting". The cell separator allows for very efficient correction of hyperviscosity syndrome in a single, three or four hour, one venipuncture procedure.

Our single experience with cytopheresis was in a 63 year old female who presented with weakness and fatigue due to chronic lymphocytic leukemia manifested by a 320,000 peripheral white blood count, anemia, thrombocytopenia, a bone marrow "packed" with mature lymphocytes and a spleen palpable 15 cm. below the left costal margin. Daily cytopheresis was instituted to reduce tumor bulk prior to the administration of cytotoxic drugs. After three procedures, we were quite perplexed to find that the total peripheral white count was essentially unchanged, and in fact, was in the 400,000 range. This puzzling situation was resolved with the realization that the spleen size had decreased from 15 cm. to 5 cm. below the left costal margin. After a total of six procedures, which required ten days to accomplish due to anemia and thrombocytopenia, the spleen was no longer palpable, the white count was in the 100,000 to 200,000 range and the patient tolerated her chemotherapeutic agents and ensuing destruction of cells with no difficulties. Our calculations showed that we had removed 1.5 kilograms of lymphocytes! The patient has done well in the year since the cytopheresis, except for a single admission three months later for steroid induced diabetes.

In summary, selective bloodletting through cyto-and plasmapheresis is improving the quality and quantity of life in a select group of patients. The cell separators have brought the pathologists into the trenches with the primary physicians and the patients. We know we have always been there, but never so visibly! Our pheresis program has been both a source of great satisfaction and, unfortunately, at times deep disappointment, to all of us involved. It should be evident to the readers that a program such as this requires the appropriate patient, a committed primary physician, a totally involved pathologist and most of all, the dedicated support and efforts of many blood bank technologists.

References are available from the author upon request.

• Dr. Leverett, Pathology Department, South Miami Hospital, South Miami 33143.

*The Editor can attest to a successful treatment, by plasma exchange pheresis, of an acute exacerbation of Goodpasture's syndrome, including serious lung disease with hemoptysis. The plasma was exchanged on three occasions with replacement by 75% of the withdrawn plasma volume by fresh frozen plasma, 25% saline. The patient received Prednisolone and Cytoxin concurrently with the plasma exchange and subsequently. The critical hemorrhagic pneumonitis was aborted and the patient has recovered from the pneumonitic complications, although he continues as a chronic renal problem requiring hemodialysis.

Recent Advances in Immunology

Juan C. Scornik, M.D.

The Clinical Immunology Laboratory

Until not too many years ago, the only immunologic techniques (defined as the methods that measure a reaction between antigen and antibody) used in the clinical laboratory were mainly those applied to the detection of antibodies to bacterial antigens. The "serology" lab was, and in some cases still is, an appendix to the Microbiology lab. Nowadays, immunologic techniques are being applied to the measurement of such diverse analytes (thyroxin, anticonvulsants, antinuclear antibodies, haptoglobins, Bence Jones protein, B lymphocytes) that the clinical immunology laboratory can hardly be considered a subspecialty but rather a multidisciplinary section utilizing related techniques.

Immunologic tests can be classified in three broad areas: 1) Tests that measure analytes unrelated to the immune system. Of these, the most popular techniques are radioimmunoassays and enzyme immunoassays that measure, for example, hormones and drugs. 2) Tests that measure the normal antibody response to infectious agents which are utilized in the diagnosis of infectious diseases. The classical serological techniques of precipitation, agglutination and complement fixation are included in this group. 3) Tests that measure abnormal reactions of the immune system. Measurement of autoantibodies and monoclonal immunoglobulins are examples of this group.



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Discussion of indications and interpretations of tests in the first two groups cannot be realistically accomplished in a short article because it involves broad areas such as endocrinology, pharmacology and infectious diseases. For the purposes of the present review, an attempt will be made for a concise and up to date description of commonly available tests which detect abnormalities of the immune system and are useful for the diagnosis and management of certain diseases.

Antinuclear Antibodies (ANAs)

LE Cell: The discovery of ANAs followed the observation of the LE (lupus erythematosus) phenomenon. An LE cell, most frequently a neutrophil, contains a phagocytized homogeneous nuclear mass in the cytoplasm. The LE phenomenon can be induced in normal cells with serum from some SLE (systemic lupus erythematosus) patients. The factor responsible for LE cell formation was later identified as an antibody with specificity for deoxyribonucleoprotein (DNP). Thus, nuclear material sensitized with ANAs is ingested by phagocytic cells.

ANA Test: ANAs can be readily detected by indirect immunofluorescence (IIF) techniques: Cells fixed on a slide are incubated with the patient's serum and washed. If ANAs are present they will remain bound to the nuclei of the cells. A second incubation is then performed, this time with a reagent containing fluorescein-conjugated antibodies to human antibodies. Nuclear fluorescence will be observed if the first incubation led to the binding of ANAs to the nuclear material. The IIF technique for ANAs has many advantages over the LE test. It is more sensitive, less time-consuming and more objective to evaluate. For these reasons LE tests are less frequently requested and some laboratories perform ANAs when LE tests are ordered.

The major indication for performing ANAs is for the diagnosis of SLE. The IIF technique is so sensitive that a negative result practically rules out the diagnosis of SLE. However, for the same reason (high sensitivity) the test is not specific for SLE. A positive ANA may be found not

only in related conditions—Sjogren's syndrome, rheumatoid arthritis, discoid lupus, progressive systemic sclerosis, dermatomyositis, drug-induced lupus and mixed connective tissue disease (MCTD)—but also in otherwise healthy individuals. It has been reported that up to 10% of the general population less than 60 years old and 30-40% above 60 years may have positive ANAs.

Types of ANAs: While all ANAs react with nuclear material, the molecular specificity is not always the same. ANAs may react with DNA, nucleoproteins (DNP, RNP), histones, RNA and other nuclear components. Interest in these individual antibodies has been stimulated by the possibility that some may be more specific for SLE than ANAs as a whole. This has been found to be true for antibodies to double-stranded (native) DNA. Even though exceptions occur, these antibodies are largely confined to SLE patients. However, only 2/3 of SLE patients have these antibodies. Antibodies to soluble or extractable nuclear antigens (ENA) have also been found to be heterogeneous and react with different antigens. Some of these antibodies are specific for ribonucleoprotein, which are characteristic of MCTD, whereas others show specificity for a non-histone nuclear protein, the Sm antigen, which is more specific of SLE. Antibodies to nucleolar RNA have been associated with systemic sclerosis (SS).

Fluorescent Patterns: In the IIF technique, different morphologic patterns may be observed with specimens containing ANAs. These patterns have been reported to correlate, to a certain extent, with antibodies of a given specificity. For example, a peripheral or rim pattern (positive fluorescence in the periphery of the nucleus) is interpreted as due to antibodies to double-stranded DNA. Diffuse or homogeneous patterns (the whole nucleus is homogeneously fluorescent) are more frequently produced by anti-DNP antibodies, which have little specificity for SLE. Speckled patterns (fluorescent granules all over the nucleus) are produced by anti-Sm antibodies and antiribonucleoprotein antibodies, whereas the nucleolar pattern is due to the presence of anti-nucleolar-RNA antibodies. Table I summarizes the correlations of these different types of antibodies.

Practical Usefulness of the ANA Test: 1) ANAs should be ordered whenever the diagnosis of SLE is considered. A positive test is consistent with SLE although it is not specific for SLE. A negative test practically rules out SLE. 2) Although the fluorescent patterns may occasionally be helpful for some diagnostic decisions, the antibody titer is more informative than the fluorescent patterns. Titers above 1:80 most commonly are indicative of disease and in patients with SLE titers correlate with the activity of the disease. 3) In conditions other than SLE, the value of positive ANAs is unclear because no correlation between the test and any clinical parameter has been established. 4) In selected cases, antibodies to double-stranded DNA may be ordered to confirm a doubtful diagnosis of SLE or to follow the disease activity in confirmed cases of SLE.

Table I

Antinuclear Antibodies

Correlations between fluorescent patterns, antibody specificity and clinical presentation.

Fluorescent Pattern	Antibody Specificity	Clinical Correlation
Peripheral or rim	Double stranded DNA	SLE
Diffuse or homogeneous	DNP	Non-specific
Speckled	Sm	SLE
	RNP	MCTD
Nucleolar	Nucleolar RNA	Systemic sclerosis

Rheumatoid Factor (RF)

This is the traditional name given to an autoantibody which reacts with the Fc portion of IgG. The Ig class of the autoantibody may be IgM, IgG or IgA, but the commonly used tests such as the latex agglutination test detect preferentially IgM. The latex agglutination test is based on the agglutination of latex particles coated with IgG. The following comments summarize some practical aspects of the clinical application of the test. 1) Most patients with rheumatoid arthritis have positive RF. High titers may indicate a severe disease, but exceptions occur. In a given patient, titers do not change with the activity of disease. 2) Patients with rheumatoid arthritis with no RF usually have a more benign course. 3) Many other conditions may be associated with RF. Patients with Sjogren syndrome most commonly have positive RF as well as 10 to 40% of patients with other connective tissue diseases. Infectious diseases—(most notably subacute bacterial endocarditis)—chronic liver disease, chronic interstitial fibrosis of the lung, renal transplant, are conditions, among others, with a rather frequent incidence of RF. Titers of 1:20 to 1:80 may be seen in a wide variety of patients including approximately 4% of asymptomatic individuals.

Complement (C)

Hemolytic Activity: C refers to a series of serum proteins which react sequentially when they become activated, producing a series of biological actions such as cell lysis, opsonization of bacteria and leukotaxis. C activity can be quantitatively measured as total hemolytic activity and expressed in conventional units, the CH50 units. This test has technical requirements not generally available in clinical laboratories. Also, the test is not very sensitive because when some C components are

decreased to levels 30 to 50% lower than normal there is little or no change in the hemolytic assay. For these reasons this test is seldom used by the general practitioner and is mainly limited to laboratories with specialized interests, such as the detection of congenital deficiencies of C.

C3 and C4: Measurement of some C components, C3 and C4, has become a more practical choice because of technical developments. Antibodies to these components have been obtained in animals which produce precipitation of a magnitude proportional to the concentration of C3 or C4. These antibodies are incorporated into agar plates which in the presence of human serum produce precipitation rings. The diameter of the rings indicates the concentration of the analytes. This technique, radial immunodiffusion, is widely available because the agar plates can be purchased from commercial sources, no expensive equipment is required and the quality of the results is acceptable for clinical purposes. More sophisticated laboratories measure the light scattering produced by the precipitation of antigen and antibody (nephelometry), which renders the technique more precise and sensitive. Decreased C levels are seen in SLE, acute post-streptococcal glomerulonephritis and membranoproliferative glomerulonephritis. C levels may also be low in other conditions—serum sickness, other connective tissue diseases, hemolytic anemia, allografts, hyperglobulinemia and renal and liver diseases—which limits the clinical value of the test. In hereditary angioneurotic edema there is a characteristic decrease in C4 levels. The diagnosis can be confirmed if a decrease of the C1 inhibitor is documented. C1 inhibitor measurements are available from reference laboratories.

Histocompatibility Antigens

Besides the acknowledged usefulness of HLA typing for transplantation purposes (bone marrow and kidney from related donors), it has been established that there is an association between certain diseases and some HLA antigens. These associations have contributed enormously to the understanding of the genetic factors involved in diseases with autoimmune reactions. However, they have not been found to be clinically useful and HLA typing is usually not necessary for diagnostic purposes. HLA antigens are present in most cells of the organism and they are usually determined on mononuclear blood leukocytes. Leukocytes from the patient are incubated with a panel of antibodies of known specificity and then submitted to the lytic action of complement. Even though it is possible to screen leukocytes from a patient against a single antiserum, for example anti-HLA-B27, it is best to perform a complete typing to avoid erroneous interpretations in instances of abnormal or intermediate reactions with the reagents utilized.

Serum Immunoglobulins (Igs)

Igs are antibodies which arise as a consequence of an antigenic stimulation. They are proteins well characterized structurally, made up of four polypeptide chains, two heavy chains and two light chains.[4] In spite of having the same secondary configuration, very few Ig molecules are exactly alike because the amino acid sequence that recognizes one antigen is different from the amino acid sequence recognizing another antigen. As a consequence, Igs form a heterogeneous group of molecules and that can be readily seen in a serum protein electrophoresis (SPE). The broad base of the gammaglobulin region (Igs) indicates slightly different electrophoretic mobility of individual molecules. A contrasting example is the serum albumin. Albumin molecules are alike, they have the same electrophoretic mobility and in the SPE they form a narrow spike.

Ig Classes: Igs are classified in five classes on the basis of their heavy chain structure; IgG, IgM, IgA, IgD and IgE. Igs of any of these classes have one of two possible light chain types; kappa or lambda. Approximately 70% of all Igs have light chains of kappa type and 30% are of lambda type. IgG, IgA and IgM are the most prominent Igs and they can be individually quantitated by a number of immunologic techniques. For example, antibodies to IgG produced in rabbits induce a precipitation of normal serum which is proportional to the concentration of IgG. The precipitation can be measured in radial immunodiffusion plates or by nephelometry, as described for C3 and C4.

Hypogammaglobulinemia: The clinical usefulness of Ig quantitation is very limited. In adults, the common variable hypogammaglobulinemia is the most frequent immunodeficiency condition. This is a heterogeneous syndrome in which hypogammaglobulinemia is acquired and concomitant with other diseases such as lymphoma. Usually, all Igs are decreased and this is readily detected with the SPE showing low gammaglobulins. Quantitation of Ig documents the classes involved and may help in patient follow up. In children, the congenital immunodeficiencies present a different problem. The extent of the deficiency should be thoroughly assessed, not only regarding serum Igs and complement, but also including quantitation and functional status of blood leukocytes, especially B and T lymphocytes. Such patients should be evaluated in specialized centers because of the possibilities of successful treatment with bone marrow transplants and other procedures. Quantitation of Igs when the gammaglobulins are normal in the SPE is rarely indicated. Examples of these rare instances are to support the diagnosis of Wiskott-Aldrich syndrome (normal IgG, high IgA), ataxia telangiectasia (normal IgG, low IgA) or myelomas with no Ig spike in serum (all classes may be low).

Polyclonal Hypergammaglobulinemia: Broad elevations of gammaglobulins as detected in the SPE are known to occur mainly in chronic infections, connective tissue diseases and liver diseases. These elevations are said to be polyclonal because they involve many different types of antibody molecules with different electrophoretic mobility. Thus, it is not surprising that when individual Igs are quantitated, in most cases all are elevated to a greater or lesser extent. From a practical standpoint, quantitation of Igs in patients with polyclonal hypergammaglobulinemia is not indicated because the laboratory results produced do not help in the diagnosis or management of such patients.

Monoclonal Hypergammaglobulinemia: In some patients there is an elevation of Igs which in the SPE shows as a narrow gammaglobulin spike, similar to the albumin spike, instead of the characteristic broad gammaglobulin band. These elevations are referred to as monoclonal because all individual Ig molecules in the spike are identical and produced, in most instances, by an abnormal clone of antibody-forming cells. Monoclonal spikes are characteristic of multiple myeloma, but they are also seen in Waldenstronn's macroglobulinemia, lymphomas, and, less frequently, in a variety of malignant and non-malignant conditions, including asymptomatic individuals. The monoclonal nature of a gammaglobulin spike can be further supported by quantitating individual Igs. Only one Ig class will be markedly elevated, the others remaining normal or low. In myeloma patients a typical finding would be, for instance, a pronounced monoclonal elevation of IgG, whereas IgA and IgM levels would be subnormal. When the myeloma cells produce only light chains, there is no spike in the SPE and all Ig classes may be decreased. During remission periods the spike, if present, becomes smaller and the other Igs return close to normal levels. In non-malignant conditions in which a monoclonal hypergammaglobulinemia is found, the spike is usually smaller than those seen in myeloma and the concentration of the other Igs is usually normal.

Immunoelectrophoresis (IEP): This method combines the electrophoretic technique with immunoprecipitation. The first step consists of a routine electrophoresis of the specimen. In the second step, an antiserum to the protein under study (for example, IgG) is added. This antiserum will produce a precipitation arc only in the zone to which IgG migrated after electrophoresis. The location and shape of this arc will be different from the arcs produced by anti-IgA and anti-IgM. If there is a monoclonal increase in any of the Igs an alteration of the arc will be noticed. The most common indication for performing a serum IEP is to confirm the monoclonal nature of a hypergammaglobulinemia by testing for light chains. As mentioned before, a narrow spike in the gamma zone of the SPE with an elevation in only one Ig class after Ig quantitation is highly suggestive of monoclonality. However, a definitive proof can be obtained testing for light chains. The suspicious spike, if it is monoclonal, should have only one type of light chain, either kappa or lambda, whereas if it is polyclonal, both types will be detected. Thus, if the spike is truly monoclonal, for example IgG class kappa type, the IEP will show an abnormal arc with anti-IgG and an abnormal arc with anti-kappa in the same location and with the same shape as the anti-IgG arc. If the IgG elevation is not monoclonal, similar arcs will be detected with both anti-kappa and anti-lambda. Infrequently, real monoclonal spikes may not react with either anti-kappa or with anti-lambda. This is a laboratory indication that the spikes are made exclusively of heavy chains and are characteristic of some lymphomas referred to as heavy chain diseases for this reason.

Bence Jones Protein: Urinary Bence Jones proteins are the Ig light chains, either kappa or lambda. Light chains have a molecular weight of 25,000 and filter freely through the glomerulus. Light chains precipitate when the urine is heated to 60°C and redissolve at 100°C. This property is very specific of light chains and is the basis of the Bence Jones test, but sometimes the presence of other proteins may interfere. Bence Jones protein in urine electrophoresis shows as a spike in the gamma region and urine IEP detects an arc with either anti-kappa or anti-lambda. This last method is confirmatory of a monoclonal gammapathy which in cases of light chain myeloma may be the only laboratory test to resolve the nature of a plasma cell infiltration in the bone marrow.

IgD and IgE: The serum concentration of these two Igs is much lower than the other three and their measurement is indicated in selected cases. The function of IgD is unknown and the only situation for its measurement is to rule out IgD myeloma which is rare. IgD myeloma may be suspected in patients with a gammaglobulin spike and no elevations of IgG, A or M. Also, some apparently light chain myelomas may be IgD myelomas having a monoclonal IgD slightly elevated and undetectable in the SPE. In all these instances an IEP using anti-IgD will reveal the abnormality. IgE myelomas are very rare and laboratory quantitation of IgE is almost always related to its participation in allergic diseases. IgE levels are normally very low and most laboratories that measure it utilize radioimmunoassays. Elevated IgE may be observed in asthma and other atopic conditions, and parasitosis. However, normal values are broad and overlap with those of allergic patients. Because of the problems for their interpretation, IgE levels remain in the list of specialized tests.

New Tests and Future Trends

There are a number of tests that, although not having clinical applications at the present time, represent potentially important tools for the future. Some of them are mentioned briefly only as representative examples and not as a comprehensive list.

Lymphocytotoxic Antibodies: These may be found in patients with SLE and related conditions. They lyse lymphoid cells in the presence of C.

Immune Complexes: These are characteristic of SLE but may be present in other immune complex diseases and other conditions, including neoplasias of different kinds. Quantitation can be done measuring some properties of immune complexes such as C1 binding or binding to lymphablastoid cell lines having Fc receptors.

T and B Lymphocytes: T lymphocytes are recognized by their capacity to form rosettes with sheep erythrocytes, whereas B lymphocytes are identified by the presence of surface Igs, as detected by immunofluorescence. Specialized centers are using these determinations to study patients with immunodeficiency syndromes and to differentiate variants of acute lymphoblastic leukemia.

Nephritic Factor: This factor appears to be an autoantibody directed to some antigens present in the 3rd component of C, breaking down C3 *in vitro*. It has been described in patients with hypocomplementemic mesangiocapillary glomerulonephritis and in patients with partial lipodystrophy with or without nephritis.

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The Case For "Routine" Screening of Thyroid Function

Laudie E. McHenry, M.D.; Judith E. Loebel, M.T., B.A., and Philippe Saxe

The purpose of this study was to assess the cost effectiveness and patient benefit status of the method by which we provide thyroid function studies to our patients. For several years, a basic thyroid study, the Free Thyroxine Index, which will be described in greater detail below, has been a component part of our so-called "routine" diagnostic chemical profile. The term "routine" is not used synonymously with mandatory, but rather to distinguish the chemical profile, which is ordered on most of our diagnostic workups. Other than the thyroid study, the profile consists of the 20 test SMAC profile, together with 4 calculated values. The addition of the FTI to this profile gives rise to the term SMAC-27. This study is an assessment of approximately 16,000 thyroid function studies performed in this laboratory during a 24 month period.

As performed in our laboratory, the Free Thyroxine Index (FTI) is a calculated value, the product of our T-3 Uptake study, multiplied by the T-4 value. We have ascertained the normal range of our population to be as follows:

ADULT - 1.65-3.75	NEONATAL-3.50-7.88 (1-7 days of age)

Our T-4 test is the total circulating serum thyroxine, measured by radioimmunoassay, utilizing the T-4 RIA diagnostic kit reagents from Abbott Laboratories. The T-3 Uptake test component of the FTI is of specific value in evaluating the unsaturated binding capacity of the thyroid hormone carrier proteins, thyroxine binding globulin (TBG). This part of the FTI study is performed by the use of the MAAT-3 kit produced by Diagnostic Corporation of America. By the use of these two tests we have a direct measurement of the circulating total serum thyroxine, and also an assessment of the thyroxine binding globulins or protein status in the serum. The normal range of the serum T-4 concentration in euthroid adults has been determined to be 5.0 to 13.0 ug%. The normal value for the T-3 Uptake study has been determined to be 23-38% in adults.

To minimize the length of time necessary for definitive thyroid function classification, we utilize

progressive confirmatory testing when we determine that there is an abnormal FTI. This progressive confirmatory testing means that we will automatically perform a TSH study (Thyroid Stimulating Hormone) whenever we find a low FTI value. By the same token, we will perform, automatically, a circulating total T-3 (Triiodothyronine, not to be confused with the T-3 Uptake test discussed above), by the utilization of the FTI as the basic screening thyroid function study, and with the progressive confirmatory testing, as indicated, we believe that we offer our patients a thyroid status classification with a validity well above 95%, probably approaching 98%. The classification of thyroid status is obtained with the utilization of one specimen and with no specific request from the attending physician needed, other than the initial request for the basic diagnostic chemical profile. The choice of the circulating total T-3 as a progressive confirmatory test (in the case of an elevated FTI) has been made because of the fact that the circulating Triiodothyronine is the most consistently elevated component in hyperthyroidism, frequently elevated when the serum thyroxine may be at a normal level. In the progressive confirmatory testing for low FTI values, the TSH or Thyroid Stimulating Hormone assay has been selected because the TSH level is a very sensitive index in the diagnosis of primary thyroid failure. When the failure is at the thyroid gland level (primary hypothyroidism), there is a marked and rapid elevation of TSH level. Obviously, if the failure is at the hypothalamic or pituitary level, the basal TSH level does not show elevation and other tests must be utilized to further evaluate the thyroid function status.

It has been well documented that abnormal values, in the measurement of serum thyroxine (T-4), can be caused by conditions other than thyroid dysfunction. These are physiologic, chemical, and other disease states. For the most part, these non-thyroid causes of abnormal serum thyroxine levels are related to abnormalities of thyroid hormone binding by proteins, both globulin and prealbumin proteins. In most cases, the calculation of the Free Thyroxine Index, as we report, minimizes the effect of these non-thyroid causes of abnormal serum thyroxine levels. However, when there is severe effect from these causes, we can get abnormal Free Thyroxine Index values also. Thus, the need for the progressive confirmatory testing, as described previously. Although abnormal protein binding is a major cause for non-thyroid abnormalities of the serum thyroxine measurement, there are other causes, most of which are poorly understood. Table 1 reflects our general thinking as to the factors that influence the T-4 concentration and physical state of thyroxine in the blood.

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Table I

Factors that influence concentration and/or physical state of T-4 in blood.

A. Factors that DECREASE the total thyroxine in serum:

1. Thyroid dysfunction;
   - (a) Primary Hypothyroidism
   - (b) Pituitary (or hypothalamic) hypothyroidism.
   - (c) Suppression of thyroid gland function by administration of T-3 (Triiodothyronine).

2. Decrease in hormonal binding;
   (a) Decreased T-4 binding by thyroglobulin:
      Androgenic and anabolic steroids.
      Masculinizing disorders.
      Excess glucocorticoids.
      Dilantin.
      Active acromegaly.
      Nephrotic syndrome, chronic hepatic disease, or any protein losing disease.
      Acute illness, surgical stress, acidosis.
      Genetic deficiency of thyroglobulin proteins.
   (b) Decreased T-4 binding by thyroidbinding prealbumins;
      Salicylates
      Penicillin
      Nephrotic syndrome
      Acute illness or surgical stress
      Hyperthyroidism. (T-3 thyrotoxicosis)

B. Factors that INCREASE the total thyroxine in serum:

1. Thyroid dysfunction:
   (a)Hyperthyroidism.
   (b) Hormonal biochemical synthesis defects.
   (c) Administration of T-4 or dessicated thyroid in excess.
2. Increase in hormonal binding
   (a) Increased binding capacity of thyroglobulin.
      Estrogens; oral contraceptives.
      Pregnancy.
      Neonates.
      Acute porphyria.
      Hepatic disease (acute).
      Perphenazine (trilafon).
      Genetic increase in binding capacity.
   (b) Increased binding by thyroid binding prealbumin.
      Androgens
      Prednisone
      Active acromegaly

We have analyzed a total of 15,891 Free Thyroxine Index tests which were performed between July 1, 1977 and July 1, 1979. In this total number of tests, we find that 40.4% are males, 59.6% of the total number are female. Specific age distribution has not been determined with the exception of the abnormal results, which will be reported subsequently. In this study, duplicate studies on the same patient were excluded, when recognized. During this same period of time, total hospital admissions were 28,071, of which 44% were males, 56% females. Therefore, on the basis of sex distribution, the patients analyzed in the study would appear to represent a valid cross-section of the hospital population. 9,995 of the hospital admissions were Medicare recipients, and therefore, in the elderly age brackets, for the most part. Such patients represent 36% of total hospital admissions. Unfortunately, further age break-down, as will be discussed later in the abnormal result categories, was not attainable for the total hospital admissions. However, it can be stated that less than 10% of the Medicare covered patients are covered under programs other than the elderly category.

In the evaluation of the results of the FTI test, we selected all abnormal results for further study. We then evaluated all the known laboratory data on these patients, distributed a questionnaire to the attending physicians (the questions of this questionnaire are indicated below) and, in selected patients, we reviewed clinical hospital charts.

Questionnaire for Clinical Information

I. Does this patient have any of the below listed conditions, either as a primary or secondary condition? If so, please circle or check the conditions present in this patient, or indicate "None".

None
Primary hypothyroidism
Secondary hypothyroidism
Hyperthyroidism
A masculinizing disorder
Idiopathic or inherited decrease or increase of TBG
Acromegaly
Inborn thyroid hormone synthetic defect
Hydatidiform mole
An acute hepatocellular disease
Acute intermittent porphyria
Myocardial infarction
Pregnancy
Terminal illness (specify type)
Gallbladder attack (acute)
Diabetes
CVA

II. Was the patient receiving any of the following medications at the time of the thyroid study?

None
T^3 (Triiodothyronine)
T^4 (Thyroxine)
Dessicated thyroid
Androgenic steroids
Anabolic steroids
Glucocorticoids
Dilantin
Salicylates
Penicillin
Estrogens
Oral Contraceptives
Heparin
Other drugs of possible significance:
_____
_____

III. Please indicate your primary diagnosis of patient's condition at time of test.
IV. Please indicate any other significant or secondary conditions that this patient has.
V. Do you consider this patient Euthyroid?

Source of Requests for Thyroid Function Tests:

At various times in the last several years, we have made spot surveys to determine the source and status of requests for Thyroid Function Studies. The majority of the tests for Thyroid Function Studies have come to the laboratory as a component part of the SMAC-27, the diagnostic chemical profile. The actual percentages, so ordered, have ranged from 77% to 90%. To rephrase, over 80% of our requests for Thyroid Function Studies are submitted as a part of the "routine" screening chemical profile, and are not submitted specifically as primary requests for Thyroid Function Test.

Results of Survey

As previously noted, a total of 15,891 basic Thyroid Function Studies were analyzed, comprising a twenty-four month period. The basic screening test is the Free Thyroxine Index Study, as previously discussed. Of the total number stated, 831 abnormal FTI's resulted. This number of abnormal results equals 5.3% of the patient population studied. Subsequent confirmatory studies indicated that abnormal FTI studies, due to thyroid dysfunction, were present in 383 patients, or 2.4% of the total patient population studied. An almost equal number (372 patients or 2.3%), were abnormal FTI tests, due to non-thyroid disease. Table II categorizes the various major and minor classifications made as a result of these studies. The various categories will be discussed briefly in subsequent paragraphs, in the order that the categories appear in the table.

LOW FTI DUE TO THYROID DYSFUNCTION

This is the largest major category demonstrated in the Thyroid Dysfunction group. This group represents 1.6% of our total patient population studied.

Low FTI, Confirmed Primary Hypothyroidism—This is by far the largest single group of patients having Thyroid Dysfunction. The total number of such patients is 219, representing 1.4% of the total patient population studied. It should be noted in this group that over 80% of these patients are in the age category above 50 years of age, also that 65% of these patients are female.

Low FTI, Confirmed Secondary Hypothyroidism-A total of 9 patients comprises this group, with all but one being in the age group above 50 years of age.

Low FTI, Because of Treatment of Hypothyroidism by T-3—(See earlier discussion)—24 such patients were found. All but two of these were in the age group above 50 years of age, and all but three were in female patients.

LOW FTI, NON-THYROID DISEASE

This major group of 256 patients comprised also 1.6% of the total patient population studied. The physiologic, chemical and other reasons for some of these results have been previously discussed in the earlier discussion. In the following paragraphs only the groups with significant numbers of patients will be discussed further.

Low FTI, Salicylate Therapy—As noted in the earlier discussion, Salicylate Therapy interferes with T-4 binding by proteins, probably the pre-albumins. Twenty-five patients comprise this group, with the majority being above the age of fifty, and also female. Clinical information indicated that most of these patients were arthritic.

Low FTI, Malignancy—Although a low number category, probably some comment should be made. All of the malignancies exhibiting an associated low FTI study were found to be in patients with breast carcinoma and were on varying stages of radiation therapy and chemotherapy. We were unable to determine any significant difference between these cases, and those cases of malignancy which also had a high FTI. See a subsequent paragraph for a more specific break-down of malignancy patients, with both high and low FTI.

Low FTI, Liver Disease—This category comprised a rather large number of patients (50), with 84% being in the age group above 50, and the majority being female. Most of these cases had associated diminution in serum proteins, associated with chronic liver disease.

Low FTI, Dilantin Therapy—Dilantin is a well known cause of decreased FTI study, because of the interference with T-4 binding by Thyroglobulin. However, we were surprised at the relatively small number (15) of Dilantin Therapy patients which we demonstrated. The great majority of these were in the age range above fifty years.

Low FTI, Diabetes Mellitus—This group of patients, a total of 23, were cases in which diabetes mellitus was the primary diagnosis and no secondary complications listed which should affect the FTI. Over 90% of these were encountered in the age range above fifty, while the sexes were essentially equally represented in this group. During the period of time of this study, there were a total of 266 patients in the hospital with the primary discharge diagnosis of diabetes mellitus, apparently comparable to the cases showing the low FTI

TABLE II

CATEGORIZATION OF ABNORMAL THYROID STUDIES
(Total Number of All Thyroid Studies Analyzed = 15,891)

FTI CATEGORIES	SEX		AGES			Subgroup Totals	Major Category Totals
	M	F	0-30	30-50	Above 50		
All Abnormal FTI's	317 (38%)	514 (62%)	33 (4%)	150 (18%)	648 (78%)	-	831
No Information or Insufficent to Categorize	-	-	-	-	-	-	76
IA - Low FTI, Thyroid Dysfunction	-	-	-	-	-	-	252
Confirmed Primary Hypothyroidism	76 (35%)	143 (65%)	7 (3%)	33 (15%)	179 (82%)	219	
Confirmed Secondary ("Pituitary") Hypothyroidism	3 (33%)	6 (67%)	0	1	8	9	
Hypothyroidism, on T-3 Treatment	3 (12%)	21 (88%)	1	1	22	24	
IB - Low FTI, Non-Thyroid Disease	-	-	-	-	-	-	256
Salicylate Treatment	9 (36%)	16 (64%)	1	6	18 (72%)	25	
Stroke, C.V.A., Etc.	5	2	-	-	7	7	
Malignancy (All Are Breast Cancer)	-	5	-	3	2	5	
Liver Disease	20 (40%)	30 (60%)	2 (4%)	6 (12%)	42 (84%)	50	
Dilantin Treatment	8	7	0	3	12	15	
Diabetes Mellitus	10 (44%)	13 (56%)	0	2 (9%)	21 (91%)	23	
Chronic Lung Disease	16 (62%)	10 (38%)	0	0	26	26	
Chronic Heart Failure	14 (78%)	4 (22%)	0	2	16	18	
Chronic Renal Disease (Dialysis Patients)	33 (60%)	22 (40%)	5 (10%)	14 (25%)	36 (65%)	55	
Anemia/Blood Loss	14 (44%)	18 (56%)	2	2	28 (88%)	32	
IIA- High FTI, Thyroid Dysfunction	-	-	-	-	-	-	131
Confirmed Hyperthyroidism	20 (22%)	69 (78%)	17 (20%)	27 (30%)	45 (50%)	89	
Hypothyroidism, Treated by T-4	3 (8%)	37 (92%)	2	7	31 (78%)	40	
Thyroiditis	-	2	-	2	-	2	
IIB- High FTI, Non-Thyroid Disease	-	-	-	-	-	-	116
Malignancy (See Text)	9 (25%)	26 (75%)	0	2	33 (94%)	35	
Myocardial Infarction	22 (55%)	18 (45%)	0	2	38 (95%)	40	
Acute Gallbladder Disease	3 (20%)	12 (80%)	0	4 (27%)	11 (73%)	15	
Acute Infection, Including Gangrene	6 (24%)	19 (76%)	6 (24%)	5 (20%)	14 (56%)	25	
Anticoagulant Treatment (heparin)	-	1	-	-	1	1	

NOTE: Percentages are applicable only within the category listed and are comparable only horizontally.

studies. Speculation is made that there may have been multiple endocrine disorders associated with this small group of diabetics, although this has not been proven in this group.

Low FTI, Chronic Lung Disease—This group of patients, comprising a total of 26 patients, had primary diagnosis of chronic lung disease, with no other specific conditions listed which would allow the cause of the low FTI to be otherwise categorized. All of these were in the age range above 50 and approximately two-thirds were males.

Low FTI, Chronic Heart Failure—This group comprised 18 patients, all but two being in the age range above 50, as would be expected, and all but four being males. These cases were unrelated to acute myocardial infarction, a category which will be discussed later. We have concluded that the reason for the low FTI must be related to diminished protein functional capability, secondary to the heart failure status.

Low FTI, Chronic Renal Disease—(Dialysis patients)—Fifty-five patients were seen in this category, with 65% seen in the age range above 50, but this type patient was seen in all age ranges. Interestingly, about two-thirds of these patients were males. The low FTI result is considered to be due to protein losing disease, nephrotic syndrome, etc.

Low FTI, Anemia/Blood Loss Problems—This category comprised 32 patients. These anemias did not include the anemias due, as secondary complications, to primary hypothyroidism. It is thought that this category of low FTI must be due to protein dysfunction, related to the anemia and blood loss problems. Eighty-eight percent of these were found in the age group above 50 years, with sexes essentially equally represented in the category.

HIGH FTI, THYROID DYSFUNCTION

This category consisted of 131 patients, representing slightly less than 1% of the total patient population studied.

High FTI, Confirmed Hyperthyroidism—This category of elevated $\overline{FTI}$ is comprised of 89 patients. It should be noted that 50% are in the age group above 50 years of age, and almost 80% are female.

High FTI, Hypothyroidism Treated by T-4—Forty patients were in this category and 31 (78%) of these were in the age group above 50 years, with over 90% being female. See earlier discussion concerning this category also. Most of these cases showed only mild to moderate elevations of the FTI. We are not particularly concerned about most of these patients. Over the years, we have encountered many patients who have a feeling of well-being, and apparently a more normally functioning general metabolism, only when the chemical thyroid function studies are somewhat elevated. Such patients, when regularly followed by thyroid function studies, are considered to be under appropriate treatment.

High FTI, Thyroiditis—Only two patients were found to be in this category. Transient hyperthyroidism is a well known phase of thyroiditis.

HIGH FTI, NON-THYROID DISEASE

This is the smallest of the major categories, comprising 116 patients, or 0.7% of the total patient population studied. However, some of the more interesting sub-groups are found in these patients.

High FTI, Malignancy—Thirty-five patients were found to be in this category, thirty-three of whom were above the age of 50, and 75% were female. Reference is made to the malignancy category related to low FTI's previously discussed. A total of nine breast malignancies, all having radiation and/or chemotherapy and being in varying stages of metastatic disease, are found in the two categories. Thus, the low FTI and the high FTI, with malignancy of the breast, are about equally distributed between the two FTI results. Three of these breast malignancies had been known to be on thyroid therapy for hypothyroidism, preceding their malignancy. However, these were not determined to be chemically hyperthyroid on the confirmatory test. Study of the records of these breast malignancies fails to reveal any significant difference recognized between those that yielded a low FTI and a high FTI. Other studies in the literature have dealt with the problem of low or high thyroid function studies related to advanced breast carcinoma. Some studies have indicated that the mean TSH level in cases of advanced breast carcinoma is higher than the general population, including other malignancies. However, no specific answer to this problem is, as yet, known. For those readers who would like to read further on this topic, the following articles are suggested: The Lancet, May 1974, page 885 ff; Cancer, Vol. 41, page 666 ff, 1978; Cancer, Vol 43, page 1434 ff, 1979. Other malignancies represented in this group were six cases of pulmonary malignancy, three cases of malignancy of the urinary bladder, one patient with gastric carcinoma, two patients with papillary carcinoma of ovary, one case of leukemia, seven cases of colon carcinoma, one case of uterine carcinoma with amyloidosis, one case of prostatic carcinoma, one case of malignant lymphoma, and one case of malignant

melanoma. In studying these cases, there was consideration given as to whether there may or may not be ectopic foci of TSH production related to these tumors. If this is the case, we have not been able to demonstrate TSH elevation in these cases by the method that we utilize. This may be the topic of future studies.

High FTI, Acute Myocardial Infarction—Forty cases comprised this group, with 95% being in the age range over 50 years, with about equal distribution between the sexes. During the period of time of the study, there were a total of 420 acute myocardial infarctions hospitalized. We believe that the elevated FTI, in these 40 cases of myocardial infarction, is most likely related to heparin therapy, which most of our acute infarctions receive. However, we are at a loss to explain the fact that we do not see a higher number exhibiting the elevated FTI. A probable explanation may be related to the time relationship between heparin administration and the time the FTI specimen was obtained.

High FTI, Acute Gallbladder Disease—Fifteen cases were found in this category, with approximately 75% found in patients in the age range above 50 years, and 80% being female. This category has been seen on each occasion that we have made a survey of our thyroid results and appears to be a distinctly significant category. In all of these cases, the primary disease process is an acute gallbladder disease, without other significant disease apparent. However, during the time period of the study, there was a total of 106 patients with the primary diagnosis of acute cholecystitis. As of this writing, we do not understand the reason for the elevated FTI in this small group of patients.

High FTI, Acute Infection, Including Gangrene—Twenty-five cases were seen in this category. Ordinarily, we see the effect of a severe acute illness, surgical stress, or gangrene, as a cause of a decrease of the total thyroxine. However, these twenty-five cases are clearly categorized as the primary illness being acute infectious process, including some cases of gangrenous limbs. Most, but not all, of these cases were in the age range above 50 years, but all age ranges were represented. Over 75% of these cases were female.

High FTI, Anticoagulant Therapy (Heparin)—We were surprised to find such a small number of heparin anticoagulant therapies demonstrating a high FTI, since we had presumed that the high FTI seen with acute myocardial infarctions are related to heparin therapy. Perhaps there are other factors in the infarction group, that we have not yet recognized.

Age Adjustment Considerations

Since this is a retrospective study, we found that the age categories of patients, used in the survey, were not directly applicable to the general patient data obtainable from the hospital. However, I believe that certain conclusions can be drawn. We know that almost 10,000 patients of the general hospital population are in the Medicare age group. This amounts to 36% of our hospitalized patients.

I believe that it is conservative to assume that an additional 14% of our patients are in the age range of 50 years to the Medicare age bracket. This would mean that 50% of our patients are in the age group of 50 years and older. This seems an entirely conservative figure, as far as the authors are concerned.* If this assumption can be accepted, then referring to the data in Table II will show that slightly more than 8% of the patients above 50 years of age were found to have abnormal FTI results. The additional data in Table II would indicate that abnormal FTI values due to thyroid dysfunction, both hypothyroidism and hyperthyroidism, amount to 4.7% of the patient population above 50 years of age.*

Summary

We believe that we have adequately demonstrated the patient-benefit of "routine" Thyroid Function Screening of hospital patients, especially in Florida. If not all ages are to be screened, certainly all patients above the age of 50 years should be screened for thyroid disease. In the general patient population (all ages), there was a yield of confirmed thyroid dysfunction in 2.4% of our total patient population. An equal number showed abnormal thyroid function studies due to non-thyroid disease, needing classification of the etiology of the abnormal thyroid studies. When we adjusted for age consideration, with emphasis on those patients above 50 years of age, we found that a conservative figure for abnormal FTI results in the age group above 50 years is in excess of 8%. Also, in the age bracket above 50 years, 4.7% are found to have abnormal FTI studies due to thyroid dysfunction. The yield of significant thyroid disease states, which we demonstrate by our method of study, is far greater than the yield of many disease states demonstrated in more universally accepted "routine" screening studies.

***Since the submission of this paper, we have been able to precisely determine the percentage of patients in our hospital which are older than 50 years of age. The percentage of patients over 50 years of age is found to be 53.5%. Therefore, the assumptions made in the article are conservative, as was thought to be the case, and the percentages throughout the rest of the article related to this figure can be considered correct on the conservative side.**

In a general community hospital, in Florida, where there is such an extensive elderly population, a laboratory which does not provide a readily available and valid thyroid function study, for screening purposes, is rendering an injustice to the patients that it serves. The Florida practitioner should make such test(s) readily available to the patients seen in his office, also.

Authors' Supplemental Note

The "free" thyroxine study has been hailed by many as a test that would supplant the FTI (Free Thyroxine Index) as a more definitive test of thyroid function status, and one that would not be affected by many of the conditions which do affect the FTI in non-thyroid disease states. However, just as this paper is being released to the JFMA, the FDA has just initiated a series of hearings concerning many claims by the "Free" thyroxine advocates which have not proven valid in clinical practice. It seems that many of the problems, encountered in FTI evaluation, must also be considered in the evaluation of "Free" thyroxine values also. As in the case with the Free Thyroxine Index, the problems with the "Free" thyroxine studies revolve around their unreliability in patients with abnormalities in the thyroxine binding proteins. As with the Free Thyroxine Index, as we have seen, such abnormalities can be caused by many non-thyroid diseases and by a number of medications.

Even so, we are eons ahead of our thyroid studies of a few years ago. Can you remember the good old PBI days?

• Dr. McHenry, 1341 South Hickory Street, Melbourne, Florida 32901.

References are available from the authors upon request.

NOTE: The senior author wishes to acknowledge, with thanks, the long, tedious hours devoted to the compilation of the data in this paper, by Mrs. Loebel and Mr. Saxe, without whose efforts the paper would never have materialized.

On Bringing Order From Chaos: Rational Thyroid Replacement Therapy

Joseph H. Keffer, M.D.

Estimates by the pharmaceutical industry indicate that approximately 5 million individuals may be taking thyroid replacement therapy. It is well-recognized that some of those individuals who are already on therapy have not had a clear diagnosis established, and conversely, many individuals who should be on replacement therapy are not recognized. Commonly, the clinical pathologist is confronted with an inquiry regarding the significance of a serum T4 or T3 resin uptake (or various other assays) with regard to the adequacy of replacement therapy. Fortunately, there are excellent published studies providing clear guidance with regard to treatment and assessment of the adequacy of this treatment. Unfortunately, they are not widely implemented in routine practice.

Physiology and Pathophysiology

It is now well-established that the hypothalamus functions as the "master gland" controlling the pituitary which is, in fact, "a slave". Thyrotropin releasing hormone (TRH), a simple peptide composed of 3 amino acids is released by the hypothalamus directly into the portal circulation, then carried to the pituitary gland where it stimulates the discharge of thyroid stimulating hormone (TSH) by the pituitary. In turn, the thyroid gland responds to this signal, secreting a mixture of tetraiodothyronine (T4, thyroxine) and triiodothyronine (T3), predominantly the former, into the peripheral circulation, transported by thyroid binding globulin (TBG) which is present in highly variable amounts in various individuals. For this reason, the total T4 or T3

levels are often misleading when isolated. Because of their high affinity for TBG, an excess of 99% of these hormones are essentially metabolically inactive according to the current understanding of the free T4 concept. This small fraction is, at least conceptually, the metabolically active form. T4 is converted by the peripheral tissues to T3, a far more active form. Both T4 and T3 feed back to the hypothalamus and pituitary, reducing further TSH secretion in the physiologically intact dynamics of the normal individual. Given the ability to measure T4, T3, and TSH as well as TRH responsiveness, we have the tools to precisely regulate the dosage of thyroid hormone replacement which restores the euthyroid state. We define this as the intact hypothalamic-pituitary relationship.

Virtually all hypothyroidism results from exhaustion of thyroid secretory capability with depletion of peripheral circulating pools of T4 and T3. In turn, this signal is recognized in a very sensitive fashion by the hypothalamic-pituitary mechanisms resulting in an increase in TSH secretion. This response is so sensitive that it preceeds the clinical development of symptomatology. Consequently, the demonstration of a normal T4 and normal TSH excludes primary hypothyroidism. The demonstration of an elevated TSH is essential to the diagnosis of primary hypothyroidism. Since the clinical presentation of hypothyroidism is so nonspecific, and variable levels of TBG as well as other causes may result in low T4 levels or low T3 levels, one should not initiate thyroid replacement therapy based solely on the measurement of T4 or T3, but only after confirming that the pituitary agrees that these levels are significantly low and manifest this by secreting an increase in TSH hormone level. Typically, in most office patients, the TSH elevation will be obvious and not marginal. This means that if a normal value is considered to be below 8 to 10 units, then the cases in question will be 20 units, and typically much higher.

It should be emphasized that the diagnosis of hypothyroidism secondary to pituitary insufficiency is a far more difficult and complex diagnosis with many implications. This calls for the special skills of an endocrinologist who will evaluate other aspects of pituitary function. Markedly lower levels of T4 should always be pursued with this possibility in mind, however, the borderline T4 of 3.5 to 4.5 is commonly encountered in the normal population of euthyroid individuals.

Pharmacology

Numerous thyroid replacement preparations are available and it is readily accepted that they have found widespread use. The clinician should be aware of certain differences which may be, and typically are, significant. Thyroid extract is of variable composition, including amounts of T4 and T3, which are not precisely standardized. T3 alone, has the appeal of being the metabolically more active hormone. However, it is rapidly absorbed and possesses a shorter half-life than T4 and, therefore, may be associated with inconsistent levels of thyroid hormone activity. Various mixtures of T4 and T3 have been advocated as simulating the physiologic state since the thyroid gland secretes both hormones. However, it is not physiologic in the sense that the thyroid gland secretes both these hormones on a continuous basis throughout the 24 hour period, rather than in the form of a single dose or twice daily dosage, which is pulsatile. It should be recognized that the predominantly secreted hormone is T4 which is converted peripherally, on a continuing steady basis to T3. Once this fact became fully appreciated, the desirability of pure thyroxin replacement therapy became widely respected and essentially represents the predominant opinion in the various respected sources in the medical literature.

More practically speaking, the use of various forms of replacement therapy, including mixtures or extract are not subject to well controlled simple laboratory monitoring. In contrast, the administration of thyroxine in pure form has been carefully studied and excellent correlation is shown between the T4 level and the adequacy of replacement therapy. Cotton, *et al.*, in 1971, demonstrated the consistent fall in TSH levels, toward normal, as the dose of T4 was increased. This correlated with the serum thyroxine level (Figure 1). They demonstrated that at a dosage of 0.1 mg daily, that most individuals had inadequate replacement with persistent elevation of TSH (Figure 2). This corresponded to a T4 of approximately 6 ug%. Dosage reaching .15 to .20 ug/day achieved a T4 typically of 8 to 10 ug% with adequate suppression of TSH into the normal range. This work was later confirmed by Maeda *et al.*, with an elegant study. They also demonstrated that the free T4 index was not an adequate



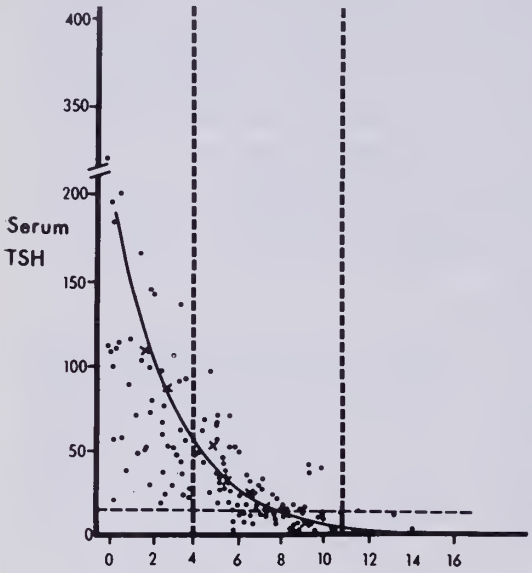
Dr. Keffer

The Author

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A native of Trenton, N.J., Dr. Keffer received his M.D. degree from Georgetown University Medical School, then took internship and pathology training at Walter Reed Army Hospital. He was Pathologist and Director of Laboratories at Anderson Memorial Hospital, Anderson, S.C., until 1978, when he became Director of Laboratories at St. Francis Hospital, Miami Beach. He is a Clinical Associate Professor of Pathology at the University of Miami School of Medicine, and Chiarman of the Council on Clinical Chemistry of the American Society of Clinical Pathologists.

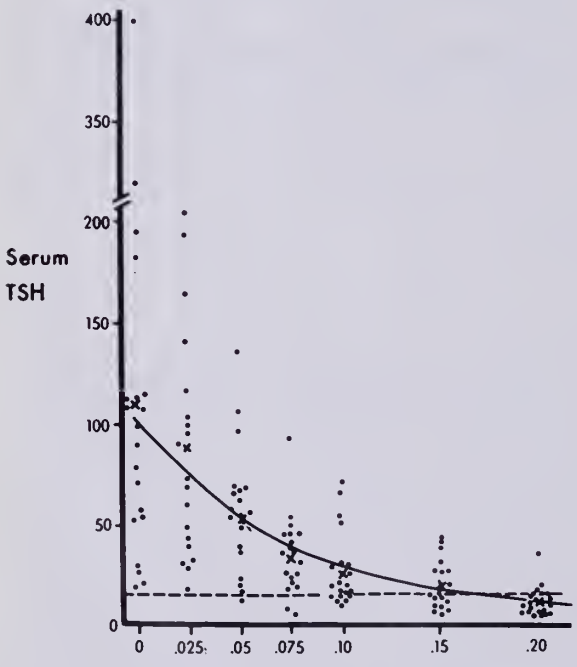
assessment of replacement therapy (Figure 3), although free T3 index was of value (Figure 4).



Relation of TSH level to thyroxine in Serum level in patients with myxedema treated with thyroxine

Cattan GE, Garman CA, Mayberry WE: Suppression of thyrtropin in serums of patients with myxedema of varying etiology. N Engl J Med 285:529, 1971.

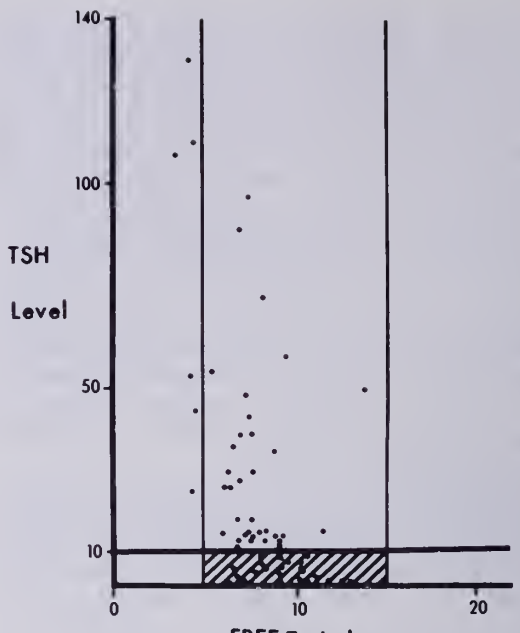
Figure 1



Relation of TSH level and Dose of T4 in Patients with Myxedema

CattonGE, Garman CA, Mayberry WE: Suppression of thyratropin in serums of patients with myxedema of varying etiology. N Engl J Med 285:529, 1971.

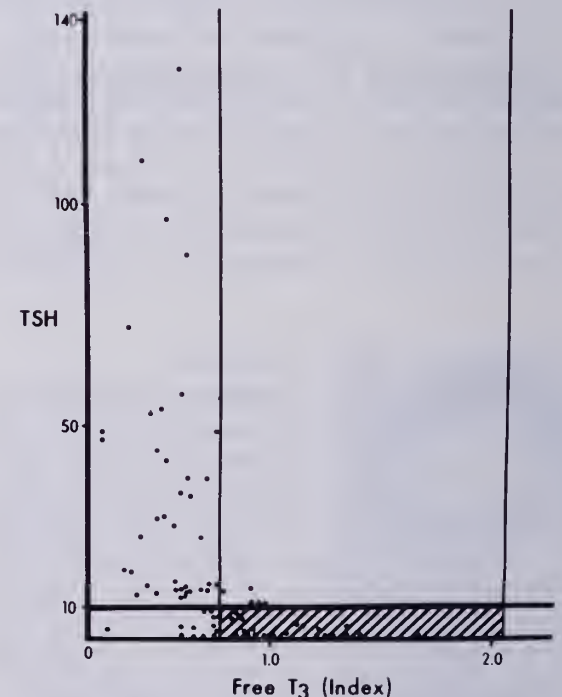
Figure 2



Non-correlation of FT_4 (index) with TSH level in treated Hypothyroidism

Maeda M. Kuzuya N, Masuyama Y et al: Changes in serum triiodothyranine, thyraxine and thyratropin during treatment with thyroxine in severe primary hypathyroidism. J Clin Endocrinol Metab 43:10., 1976

Figure 3



Correlation of Free T_3 Index with suppression of TSH in treated Hypothyroidism

Maeda M. Kuzuya N, Masuyama Y et al: Changes in serum triiadothyranine, thyraxine and thyratropin during treatment with thyroxine in severe primary hypathyroidism. J Clin Endocrinol Metab 43:10, 1976.

Figure 4

Recommended Approach to Laboratory Monitoring of Thyroid Replacement

After the initial diagnosis is established, including documentation of TSH elevation, therapy should be instituted using a dosage appropriate to the clinical status of the patient. In the elderly, or those with demonstrated cardiac disease, low dosage should be initiated followed by gradual progression with close clinical follow-up. Hypothyroid individuals may show increased sensitivity to low dosage of thyroid replacement therapy with cardiac complications. One should also be particularly aware of the possibility of simultaneous adrenal insufficiency which would predispose to the complications of excessive thyroid replacement therapy. The young individual can tolerate a more rapid increase in dosage.

As a level of 0.15 mg/day is achieved, a serum T4 level should be obtained. If below 8 ug%, one may anticipate that the TSH will be persistently elevated, while a value of 8 and 10 ug% should predict adequate return of the TSH into the normal range. If maximum confidence is required, then the TSH assay itself can be performed. This would then confirm that the particular individual in question corresponds to the generalization observed in the data previously described.

Evaluation of excessive thyroid replacement therapy is not readily achieved since measurement of low levels of TSH is not within the capability of current assays. Consequently, one should rely heavily on the clinical signs and symptoms of hypermetabolism associated with hyperthyroidism. These are far more reliable than the signs and symptoms of hypothyroidism. In the cardiac patient, it may be essential to evaluate the marginal degree of hyperthyroidism that a mild excess of thyroid replacement therapy will produce. This can be achieved by administering TRH in a dosage of 500 mg by I.V. injection and sampling the baseline TSH level as well as additional samples at 30 and 45 minutes following the injection. Suppression of the TSH response is evidence of over-replacement and a decreased dosage would be indicated.

Conclusion

Primary hypothyroidism is a common condition which is now readily defined in the laboratory by virtue of the concomitant finding a a low serum thyroxine level in association with elevation of TSH. Prior to providing replacement therapy, the significance of the lowered T4 should be evaluated by the measurement of the TSH. This is of value not only for the confirmation of the diagnosis, but ultimately as an indicator of adequacy of replacement therapy. Replacement with T4 alone is advocated because of the predictability of the pharmacologic response and the facility with which laboratory monitoring can assess the adequacy of this form of replacement therapy. A predictable dose of 0.1 to 0.2 mg can be achieved after gradual increment. Only at this point is it appropriate to measure a serum T4 level. A value of 8 to 10 ug% in association with an appropriate clinical response may be entirely adequate. The further measurement of TSH can enhance and optimize the assessment of the adequacy of thyroid replacement therapy. Inadequate suppression of TSH is unequivocal indication of persistent abnormality which, if indicated, can be pursued by further increase in dosage. Excessive replacement with resultant iatrogenic hyperthyrodism can be evaluated by TRH responsiveness.

References are available from the author upon request.

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Diagnostic Cytopathology Today

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Introduction

Although diagnostic cytopathology has only been recognized in the past 20 years as a discipline in Anatomic Pathology, it has become widely practiced in Anatomic Pathology laboratories in the United States and other countries for detecting cancers and their precursors in screening programs, as well as routine diagnostic and research work. Cytopathology is not only of value in the diagnosis of cancer or its precursors, it is also of use in the diagnosis of certain specific inflammatory processes, hormonal effects, irradiation or chemotherapeutic changes, and some specific diseases characterized by cellular abnormalities. As a relatively new branch of service pathology, it would be appropriate to review the state of the art as we know it today. This paper will discuss the basic essentials necessary to optimally apply this technique for diagnostic work and to discuss the values and limitations of cytopathology when applied to the various anatomic sites.



Dr. Ng

The Author

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Dr. Ng received his medical degree from the University of Melbourne in Australia in 1958. After training in Australia, he came to the United States where he took extra training at the Department of Pathology of Case Western Reserve University in Cleveland, Ohio. He remained in this institution where he was Professor of Pathology until 1975. He was head of the Division of Cytopathology and Department of Pathology, as well as Director of the School of Cytotechnology at the University Hospital in Cleveland from 1967 through 1975. He has been a Professor of Pathology and Director of Surgical Pathology and Cytology at the University of Miami from 1975 to present. He also is Professor of Obstetrics and Gynecology at Miami. He also holds membership in National and International Societies and has been a member of numerous committees, particularly in the area of Cytology. He has published over 50 articles in his area where he is recognized as a National and International authority.

General Considerations

As in any other diagnostic procedure, certain general considerations are basic to the optimal application and utilization of cytopathology. These include cytologic sampling for each anatomic site, proper fixation and preparation of specimens, pertinent clinical data, personnel expertise, nature of report, diagnostic accuracy and quality control.

Sampling Methods

In deciding the optimal sampling techniques for each anatomic site or organ, a knowledge of the distribution and location of lesions diagnosable by cytologic means for that system is mandatory. A combination of different sampling approaches should include cells representative of sites where lesions are potentially located. Generally it can be said that the closer the instrument is to the site of the lesion to be detected, the higher the sensitivity of that technique. Accurate sampling produces a greater number of cells in a better state of preservation which is essential for accurate interpretation. In evaluating preferred methods of cellular sampling, the simplicity and time factor of the procedure should be considered; techniques which are simple, reliable and accurate are more likely to be widely applied than complicated methods. A procedure that is time consuming and tedious is less likely to be widely accepted especially when large numbers of cases are involved. Techniques that will create great discomfort to the patient will be unpopular for both the patient and the doctor. Relative costs of sampling techniques should also be considered especially when mass screening or large numbers of cases are involved. Considering these factors, various recommended sampling methods will be discussed by organ site. They may change with time as new and better techniques are developed. Most routine cytology specimens may be collected by most practicing physicians and paramedical or technical personnel after appropriate instruction. However, some techniques require special and more complicated procedures which should be limited to those who do them regularly and have the proper expertise and facilities.

The equipment and material used should be clean,

and in some procedures collection is done under sterile conditions. Care should be taken to avoid use of oily lubricants on instruments, talcum powder on gloves, and other possible sources of contamination by foreign material. Saline can be used as a lubricant when indicated.

Fixation, Preparation and Staining of Specimens

Samples that require direct smearing on glass slides should be preserved *immediately*; a few seconds delay may result in drying of the smear and production of artifacts which may hinder evaluation of the cells. The smeared glass slide should be fixed immediately in 95% ethyl alcohol or by an appropriate spray fixative. If more than one slide is placed in a container, separating the slides with paper clips allows the ethanol fixative to penetrate between slides and insures adequate fixation. For some special histologic stains some smears may be air-dried; however, smears for evaluation by the Papanicolaou staining method-the "Pap" smear-should be fixed immediately. Slides should be immersed for at least one half hour before removal from the fixative.

Fluid specimens should be delivered immediately to the laboratory for preparation. If delay is unavoidable the fluid may be fixed promptly in an equal volume of 50% ethyl alcohol and stored in the non-freezing part of the refrigerator to retard cellular degeneration. The preserved fluid should be forwarded to the laboratory as soon as possible.

Specimens received as smears on glass slides and preserved in ethanol or spray fixative require no further preparation prior to staining. Most fluid specimens will require concentrations of the cells in fluid suspensions before transferring to slides for staining. There are many techniques available for cellular concentration and most are acceptable provided the procedure utilized does not cause undue loss of concentrated cellular material or create cellular artifacts by distortion or drying changes. Concentration of cells by centrifugation is widely practiced. After decanting the supernatant the concentrated cellular sediment can usually be smeared directly on glass slides. When cells are already partially fixed, albuminized slides may be used so that the cells will adhere to the glass. A number of devices are available commercially for centrifuging cellular material directly onto a slide.[7] A disadvantage of most centrifugation techniques is that much of the cellular sediment is lost in the transfer and smearing process.[1,4] Recently a new centrifugal cytology technique has been devised which collects and concentrates cellular material with minimum cell loss or degenerative changes. This method is far superior to any available known technique today and is particularly useful for specimens with limited cellular material.[10,11] However, this procedure is currently not commercially available for routine laboratory application.

In some samples, such as sputum, the specimen may be prepared by selecting blood-stained, mucus or more solid flecks of material, and smearing them directly onto the glass slide.

Membrane filters, while useful and relatively simple for cellular concentration, require considerable technical skill and care to provide high quality preparations; otherwise cellular distortion, drying artifacts, poor staining and other artifacts will negate its value.

If sufficient cellular material is present, specimens can be concentrated into a "cell block" by centrifugation and processed as a biopsy specimen stained with H&E stain. This method is useful when microscopic tissue fragments are present and will often complement cellular smear preparation. However, cellular detail is not as good as in cytologic smears.

The optimum number of slides to be prepared from fluid specimens will vary depending on the source and quantity of fluid submitted and may range from 2 to 6 slides per specimen. When warranted, many more slides may be prepared and evaluated.

Routine cellular smears should be stained with the Papanicolaou stain or its modifications as diagnostic criteria for most lesions are well defined and generally accepted when this stain is employed. When speed is essential as in "Rush" or "Stat" cases, a rapid Papanicolaou staining procedure is available which takes less than 3 minutes. Hematoxylin-eosin stain may be used for rapid stain; however, cytologic detail is usually inferior. When indicated, special stains may be used to complement the Papanicolaou stained smears. Wright-Giemsa stain is most useful for identifying and classifying hematopoietic cells. Periodic acid-Schiff or methenamine silver stains are useful for identifying fungi. Guard's stain is used for recognizing Barr bodies.

Clinical Data

In addition to the standard information required on requisition forms, certain other specific information pertinent to each case must be provided for optimal cytologic evaluation. This will be discussed by organ site. The exact type of cell sample must be indicated and this should not be vague. Thus, the term "Pap" smear does not provide the exact source of sampling from the lower genital tract whereas terms such as "cervical scrape," "vaginal scrape" or "cervical aspiration" are specific.

Cytopathology Report

In the practice of diagnostic cytopathology considerable information can be obtained by analyzing the cellular changes. The various stages of precursor changes may be distinguished from the infiltrating stage of cancer. A specific diagnosis of cancer can be made in cell samples. The characteristics of the cancer, including cell type, (for example: squamous cancer, small cell carcinoma,

adenocarcinoma, sarcoma) the various subtypes (such as keratinizing and non-keratinizing squamous cell cancer), the degree of differentiation-especially of adenocarcinoma; the site of origin and distribution or extent of disease may also be identified. However, specific diagnoses are dependent on adequate anatomic sampling. Non-neoplastic conditions such as herpes virus or fungal infections, irradiation or chemotherapeutic effects, regenerative or degenerative processes, may also be accurately diagnosed in cell samples. For these reasons, cytologic interpretation and diagnosis should be specific with the usage of acceptable medical terms such as those used in surgical pathology. The use of numbers or classes and the use of vague terms such as atypical, suspicious, borderline, abnormal and positive alone in cytologic diagnosis should be discontinued. The Papanicolaou classification was necessary when it was first introduced by Doctor Papanicolaou because our knowledge of cytology and of specific lesions was less well documented. Through the years, this classification has been so modified and redefined that it means different things to different laboratories or clinicians.

This recommendation should not be confused with code numbers used in coding or computer work provided the code numbers each represent a specific medical entity comparable to those used in surgical pathology coding. The use of specific diagnostic terms comparable to those used in surgical pathology permits accurate correlation with tissue and flexibility in expressing diagnostic impressions that are not possible using limited numbers or classes. It will prevent misunderstanding of diagnoses and will provide the clinician with a specific diagnosis which will assist him in planning definitive management. The result will be a more uniform and consistent diagnostic interpretation from laboratory to laboratory.

Diagnostic Accuracy

In evaluating accuracy utilizing cytologic methods, sensitivity and specificity of the sampling method have to be considered. Sensitivity measures the frequency of recognizing atypical or abnormal cells from a specific site by a specific procedure without regard to specificity of cell type of origin. Specificity of diagnosis implies recognition of a specific entity through cellular evaluation comparable to that in surgical pathology. In the use of cytologic methods for mass screening, for the detection of cancer and its precursors, the methods used should be highly sensitive whereas specificity may be less critical. However, in diagnostic work not only is sensitivity of a specific technique important, but a high degree of specificity of diagnosis is equally important. Many factors contribute to accuracy of cellular study including the individual collecting the sample, type of sampling technique, source of cellular sample, adequacy of cellular sampling, laboratory personnel evaluating the cellular smears, our knowledge of the cellular changes of various disease entities and intrinsic aspects of various disease processes under study. Accuracy will be further discussed by organ site whenever applicable.

Personnel Expertise

In evaluating a cell sample, there should be a systematic approach to the recognition of various cell types and their relationships, identification of numerous detailed cellular features for each cell type, a comparison of normal and atypical or abnormal cells of each cell type when present and the milieu of the smears. Based on the changes identified in a cell sample and the criteria of various disease entities known, it is possible to correlate the findings to a specific disease process in a larger number of cases. In this correlative approach, a definitive diagnosis can be rendered consistently and forms the basis of diagnostic cytopathology. It is however, relatively time consuming to screen a cell sample and search out abnormal cells; this requires a team effort of qualified personnel in the field.

Although other supporting personnel in a cytology laboratory are important to provide this type of service, the key people are the cytotechnologists and pathologists. Cytotechnologists should be appropriately trained and certified. One of their main responsibilities is to systematically screen the cell sample and identify significant cellular changes or other findings not normally found in a cell sample. The pathologist's function is to interpret and diagnose these abnormalities. With few exceptions, initial cytologic screening should be completed by a cytotechnologist. This is a time-consuming procedure and most pathologists either do not have the time, the training, or the mental attitude to do this properly. In terms of cost effectiveness, it is more economical for the cytotechnologist to screen and the pathologist to diagnose.

A particular problem is the laboratory that processes a small volume of cellular samples and cannot justify having a full time cytotechnologist. In the absence of a qualified cytotechnologist, the pathologist must be intimately familiar with all the optimal sampling techniques for the different anatomic sites, with fixation, and with processing procedures. He must ensure that the person processing the cytologic specimens has had adequate and proper training and is able to employ the appropriate procedures for fixation, preparation, and staining. The pathologist who deals with a small volume of cytology cases and who does not have the benefit of a cytotechnologist should be aware of his limitations in screening and interpretation. He should seek assistance more frequently when the cytologic smears are abnormal.

The use of a part-time qualified cytotechnologist

should be considered for low volume laboratories. The screening of slides away from the laboratory such as at home is not conducive to quality practice and should be discouraged. In some laboratories, there is a full-time qualified cytotechnologist to supervise the cytology section despite the small volume. The cytotechnologist's responsibilities include preparation, screening, sending out reports, keeping files, tissue correlation follow-ups, and other administrative functions. If additional time is available, the cytotechnologist is sometimes trained to assist the pathologist in other laboratory activities such as grossing of surgical specimens or special staining techniques. This approach will at least insure proper handling of cytologic material by a cytotechnologist. As a general guide, a laboratory that processes up to a thousand non-gynecologic cases per year or up to 5,000 gynecologic cases per year, or a screening volume equivalent to 50% of a technologist's time, justifies having a full-time cytotechnologist. This is the recommendation of the American Society of Cytology. This cytotechnologist can then spend non-microscopic time on other functions important to a good cytology service.

As in other branches of service pathology, the pathologist is ultimately responsible for each cytologic case processed in the laboratory. The quality of practice in diagnostic cytopathology is greatly influenced by the amount of time spent in cytology practice, by motivation and interest in cytology, and by the nature of prior training in cytology. Pathologists who provide cytology service should have adequate training as part of their pathology training programs or have attended extensive courses in this field. With very few exceptions attending a few workshops at local or national meetings alone or learning cytology "on-the-job," in the absence of any prior training in cytology, are insufficient methods for providing acceptable practice in this branch of pathology.

The responsibility of the clinician for providing an appropriate anatomic sample of optimal quality, as well as pertinent clinical data, is paramount if the laboratory is to provide quality service to the community.

Quality Control

Quality control is as important in a small volume service as it is in large cytology laboratories. Quality control may be divided into standards necessary for good general laboratory practice and those unique to cytopathology. The standard needs of a cytology laboratory should include adequate physical facilities including separate work areas for specimen preparation, microscopy and record keeping. Cytopreparation equipment and microscopes must be in superior working condition. Cytology records should include adequate specimen identification, alphabetical and numerical patient logs or indices, cross files for histology-correlated cases, diagnostic files (lesion index), adequate requisition and glass slide storage, and follow-up systems. A laboratory manual outlining these standard operating procedures is essential.

Cytologic evaluation requires interpretation of the cellular changes by the reviewer with an intimate understanding of the disease processes involved. Accurate cytologic diagnosis requires that examinations be performed by trained personnel whose expertise should be maintained by regular active practice of diagnostic cytopathology and continuing education programs. For these reasons, the standard methods for quality control in quantitative laboratory disciplines such as clinical chemistry (in which duplicate specimens or control and standard materials are used) are not applicable to cytology. The best quality control in a cytology laboratory is to insure that optimal quality of cell samples are received from the clinician and that the cell samples are evaluated by qualified cytotechnologists and pathologists. Specific diagnosis, as in surgical pathology, as well as proper supervision and good laboratory practice must be provided. These prerequisites together with some internal quality control mechanisms, continuing education sessions, and conferences are usually adequate for most laboratories. In the absence of these prerequisites other quality control methods such as rescreening negative slides are far from adequate. In fact, time consumed in these pursuits may contribute to inadequacies in the laboratory and will not up-grade the quality of service.

Organ Site

As most diagnosable entities in cytopathology are well documented, it is not our intention to present cytologic criteria for their diagnosis. Appropriate references relating to cytopathologic diagnosis have been provided for indepth study if desired.[3,5,8,9,14-21] In addition to the general principles already discussed, certain collecting methods, clinical data, diagnosis and other factors pertinent to major anatomic sites will be reviewed.

Female Genital Tract

Table I summarizes the preferred sampling methods for various diagnosable entities in cytopathology of the female genital tract. A routine gynecologic cell study should include a cervical scrape by an Ayre-type spatula and aspiration of the cervical canal by glass or plastic pipette with attached rubber bulb to provide suction. For the detection of vaginal adenosis in the absence of an obvious lesion, four-quadrant scraping of the upper vaginal wall with separate labeling of each as to anterior, posterior, left and right lateral vaginal walls is recommended. The identification of columnar and/or metaplastic cells are diagnostic of vaginal adenosis. If a viral lesion is suspected, the specimen should be obtained from the

TABLE I

Recommended Sampling Methods for Detection of Specific Lesions in the Female Genital Tract

Lesions	Vulva Scrape	Vaginal Aspiration	Vaginal Scrape	Cervical Scrape	Endo-Cervical Aspiration	Endometrial Suction	Other Endometrial Sample	Culdo-Centesis	Fine Needle Aspiration
Vulvar Lesions	+++	—	—	—	—	—	—	—	—
Hormonal Evaluation	—	—	+++	—	—	—	—	—	—
Vaginal Lesions	—	++	+++	—	—	—	—	—	—
Cervical (General)	—	+	—	+++	+++	—	—	—	—
Cervical Dysplasia	—	+	—	+++	+++	—	—	—	—
Cervical Ca. in Situ	—	+	—	+++	+++	—	—	—	—
Cervical Microinvasion	—	+	—	+++	+++	—	—	—	—
Cervical Sq. Cell Ca.	—	++	—	+++	+++	—	—	—	—
Endocervical Adenoca.	—	+	—	++	+++	—	—	—	—
Endometrial (General)	—	+	—	+	++	+++	++	—	—
Endometrial Hyperplasia	—	+	—	+	++	+++	++	—	—
Endometrial Adenoca.	—	+	—	+	++	+++	++	—	—
Extrauterine Cancer	—	+	+	+	+	+	+	++	++
Pelvic Mass	—	—	—	—	—	—	—	+	+++

+++ excellent ++ good + satisfactory —inadequate or does not apply

edge of the ulcerated area where the herpetic cellular changes are located and not from the degenerative or necrotic central area of the ulcer.

Whenever possible, pertinent clinical information must be provided by the clinician. This is particularly important in evaluating endometrial lesions. The presence of spontaneously desquamated normal-appearing endometrial cells in a cell sample may be associated with physiologic or abnormal shedding. When observed during the first half of the cycle this usually represents physiologic shedding. The presence of normal-appearing endometrial cells in the second half of the cycle or in postmenopausal women, represents abnormal shedding and an explanation must be found. Abnormal shedding of normal endometrial cells in women under 40 years of age is usually due to benign conditions such as the use if IUD's, birth control pills, endometritis, etc.; however, when observed in women over 40 years of age, in addition to benign processes, the possibility of pathologic endometrial hyperplasia and even invasive cancer should be considered whether the patient is symptomatic or not.[13] Under these circumstances and in high risk patients, some form of endometrial suction technique such as Vacutage or Vabra aspiration procedure, which may be performed in the office, is recommended. The endometrial suction technique is preferred to other endometrial sampling procedures apart from endometrial biopsy or curettage. Thus, to adequately evaluate the signifcance of endometrial cells, the age of the patient, date of last menstrual period and date the cell sample was obtained is necessary. Menopausal status and other pertinent data such as the use of IUD or hormonal therapy must be provided.

More recently, vaginal, percutaneous or transrectal fine needle aspiration has been applied as a collecting technique for patients with suspected pelvic tumors, suspected pelvic or abdominal metastasis of proven uterine cancers, and patients who were treated for gynecologic cancers to rule out persisting or recurrent disease. This procedure has reduced the number of laparotomies.

Using the optimal sampling methods recommended, the accuracy for the detection of squamous cell cancer and its precursors of the vagina and cervix, endocervical adenocarcinoma, vaginal adenosis, vulvar cancer and its precursors and the herpetic infections is over 90%. The detection rate of endometrial carcinoma and its precursors is over 80%.

Cytopathology in this system has also been used for the detection of specific infections including candidiasis, trichomoniasis, herpes, actinomycoses[2] and condyloma accuminata.[12] Irradiation effect post-radiation dysplasia, folic acid deficiency, and hormonal patterns are also recognizable and diagnosable with an accurate clinical history.

Respiratory Tract

Respiratory tract specimens are usually collected from patients suspected of lung cancer and more recently from high-risk groups to detect occult cancer or

precursor changes. The most common type of specimen is sputum obtained from spontaneous or induced cough preferably obtained early in the morning. There should be at least 3 to 5 consecutive specimens obtained if satisfactory pick-up rate is to be expected. The identification of malignant cells from one single cough specimen from a patient with proven lung cancer is about 33% and this increases to over 75% when three or more consecutive specimens are evaluated.

Bronchial brushings and washings, as part of a bronchoscopic examination are valuable adjuncts. The identification of malignant cells in bronchial washings is about 50% in cancer patients. Bronchial brushings obtained from lesions visualized through endoscopic techniques (fiberoptics) seem to be the most effective diagnostic technique. Transthoracic needle aspiration performed under biplane fluoroscopy by a radiologist or thoracic surgeon is very effective in diagnosing peripheral lung tumors; the accuracy is over 90%.

In adequate samples, a specific diagnosis for small cell carcinoma can be made in over 95% of cases, 90% for squamous cell carcinoma and primary adenocarcinoma, and 85% for large cell carcinoma. Frequently, bronchiolar-alveolar cell carcinoma can be specifically diagnosed. Although sometimes metastatic cancer may be differentiated from a primary cancer, generally this is difficult based on cytology alone.

The application of pulmonary cytologic specimens for the detection of infectious agents is of increasing importance and includes the mycotic infections, viral infections, and others such as pneumocystis carinii.

Effusions

The three major sites of effusions are the pleural, peritoneal and pericardial cavities. Routinely, smears (average of 4 slides) are made and stained with the Papanicolaou stain and one air-dried smear is stained with the Wright-Giemsa stain for recognizing hematopoietic cells. When cellular material is limited, centrifugal cytology or the cytocentrifuge technique may be used. Others prefer membrane filter techniques. When available, residual sediment may be embedded in paraffin and processed as a cell block and stained with the hematoxylin and eosin stain.

The accumulation of fluid in any of the three body cavities is always abnormal and may be broadly classified as secondary to a circulatory disorder, specific or non-specific inflammation, neoplastic or non-neoplastic obstruction at distant sites, and direct invasion by tumor into the walls of these cavities. Only malignant cells will be found in fluids when there is invasion by tumor into the linings of the various cavities. Often more than one factor contributes to effusion. The primary purpose of most fluid examinations is to rule out cancer and to differentiate primary from metastatic cancers. In practice, a difficult problem is to differentiate extremely reactive mesothelial cells from metastatic cancer or primary cancer. Reactive mesothelial cells secondary to irradiation and/or cancer chemotherapeutic agents are often mistaken for metastatic cancer and such an interpretation is more likely to be made if the patient has a history of cancer. Appropriate clinical data often will assist in arriving at the proper interpretation. In metastatic cancer, the diagnosis of adenocarcinoma, squamous cell carcinoma, small cell carcinoma and some lymphomas can be accurately made. Less frequently sarcoma cells are specifically recognized. In children, the presence of small cell malignant tumor in fluids should suggest the possibility of neuroblastoma, Wilm's tumor, Ewing's sarcoma and possibly embryonal rhabdomyosarcomas.

In most instances, especially when the patient has a history of cancer, the unequivocal diagnosis of malignant cells in fluids is taken by the clinicians as a definitive diagnosis of metastasis and tissue confirmation is usually not pursued. It is also implied that the patient has advanced disease. The clinician should correlate the clinical findings with such positive fluid before such an assumption is unequivocally made. When in doubt this should be discussed with the pathologist. Thus, such an unequivocal diagnosis of tumor cells in fluids should be made carefully and whenever there is some doubt, this should be conveyed through the report to the clinician so that other means of definitive diagnosis such as needle biopsy of the cavity linings may be employed. It is better to err on the side of conservatism when the diagnosis is equivocal in the evaluation of fluid specimens. However, as in other anatomic sites, a negative report does not necessarily imply a lack of metastasis. In a review of 100 cases of tissue-proven cancer involvement of the cavity linings, malignant tumor cells in fluid specimens were recognized in 78% of cases. In contrast, of 85 cases with a history of cancer that developed effusions, which on subsequent autopsy findings were found not to have cancer in the cavity linings, the effusions were reported not to contain tumor cells in 84 (98.8%) cases and in only one case (1.2%) were tumor cells reported in the effusion (false positive).

The application of synovial effusions and other fluid collections are more limited but should be utilized when indicated.

Cerebral Spinal Fluid

Spinal or ventricular fluid should be processed immediately. Because of the paucity of cellular material smear should be air-dried and stained with the Wright-cytology. Membrane filter techniques may be used. Smears should be stained by the Papanicolaou stain. One smear should be air-dried and stained with the Wright-Giemsa stain for evaluation of possible hematologic

components. The main application of spinal fluid cytology is for the detection of metastatic cancers or central nervous system involvement by lymphoma. Its use for the detection of primary tumors is more limited. Infrequently, specific inflammatory processes such as viral disease may be detected. Accuracy of cellular diagnosis is difficult to assess and has been reported to vary from as low as 10% and as high as 60%.

Eye

Ocular cytology has in the past been used primarily for detecting inflammatory changes by ophthalmologists. Recently its use for detection of cancer and precursor changes has been applied with a high degree of reliability. Close cooperation with the clinician in evaluating ocular cytology is important.

Urinary Tract

Malignant cells from carcinomas arising from the surface epithelium of the urinary tract desquamate readily into the urinary system and can be detected by collecting urine at various locations of the urinary tract. Cancers arising from deeper structures such as the kidney and prostate will exfoliate cells into the urinary collecting system when the tumor has grown to substantial size and disrupts the surface epithelium. Thus, cytology studies of urinary sediment are most useful in the diagnosis of carcinoma of the bladder, renal pelvis, ureter and urethra. Urine cytology is usually used as an aid in the differential diagnosis of patients who are symptomatic. The use of urine cytology for the detection of asymptomatic high-risk populations is not widely practiced in the United States but has been used to detect carcinoma *in situ* and occult cancers. The use of such a simple procedure should be more widely practiced in the detection of early cancers and precursor lesions.

Urinary cytology may be used as an adjunct in confirming the clinical diagnosis of carcinomas of the renal cortex, Wilm's tumor and prostatic carcinoma. Needle aspiration of tumors of the prostate and kidney can be accurately applied. Such procedures are less traumatic than other biopsy techniques. Sarcomas are sometimes diagnosed in urine specimens.

Other applications of urine cytology include recognizing changes secondary to irradiation and to cancer chemotherapeutic agents, monitoring for rejection in renal transplants, specific infections such as herpes and cytomegalic inclusion disease, and occasionally, diagnosis of malakoplakia by the identification of Michaelis-Gutman bodies.

Voided urine specimens usually contain fewer cells than catheterized bladder irrigation specimens and accuracy in diagnosis of bladder cancers by the latter procedure is over 85%. For voided specimens the accuracy falls to 60%. There is evidence to indicate that the use of centrifugal cytology from voided specimens will concentrate the cells in the specimen and consequently increase diagnostic accuracy. The identification of malignant cells is enhanced if ureteral catheterization or renal pelvic specimens are evaluated when an upper urinary tract carcinoma is suspected.

Alimentary Tract

Cytopathology of the oral cavity and nasopharynx is most commonly used as an adjunct to tissue evaluation of clinically suspected *in situ* or invasive cancers. Its use for detection of non-neoplastic lesions is limited and includes herpes and pemphigus.

Cell samples prepared from both esophageal brushings and washings are used most frequently in clinically suspected cancer or to detect persisting or recurrent cancer. The cancer is usually of the squamous cell type and infrequently an adenocarcinoma. Sometimes herpetic esophagitis and candida infections can be recognized.

Specimens from gastric brushings and washings are used for the evaluation of clinically suspicious malignant lesions and for differentiating benign and malignant ulcers. The container with gastric washings should be packed in ice and delivered to the laboratory for processing within half an hour to minimize rapid cellular degeneration due to the low pH of the gastric content. Cytologic specimens must be collected before radiologic procedures, otherwise they will be contaminated by barium. Exophytic tumors are more readily diagnosed by cytology whereas diffuse infiltrating non-ulcerating carcinomas are less easily diagnosed. Mesenchymal sarcomas and lymphomas that have penetrated through the gastric mucosa may be detected cytologically.

Duodenal aspiration or irrigation for cytology is more complex and time-consuming. Consequently its application is limited. It may be of value in diagnosing carcinoma of the ampulla and less useful for the diagnosis of carcinoma of the pancreas, gallbladder or bile ducts.

Similarly, colonic cytology is not widely practiced. Specimens can be obtained by irrigation or direct brushing under endoscopic control, the direct brushing procedure being the most useful. Colonic cytology may be used for differentiating benign and malignant polyps or ulcers.

Breast

Nipple secretions are collected from spontaneous secretions, secretion by "milking", or by the use of a vacuum pump. Their use complements clinical evidence of disease or mammography. Rarely are breast cancers detected by cytology alone with no clinical evidence of disease. Needle aspiration of any mass of the breast is useful in differentiating fibroadenoma, ductal papilloma and mammary dysplasia from cancer. Smears prepared

from nipple secretions or needle aspirations can provide accurate diagnoses of mammary dysplasia, ductal papilloma or ductal carcinoma when the appropriate changes are present.

Skin

Cytology diagnosis of the skin lesions has not been widely practiced because the clinican can more easily monitor suspicious lesions of the skin with office biopsy procedures than with cytologic collection techniques. There is limited application of the cytologic technique in differentiating various inflammatory processes, dermatosis, and in the detection of cancer and its precursors in most institutions. Its wider application requires further study of indications for use.

Aspiration Biopsy Cytology

Aspiration cytology with the aid of a fine needle is particularly useful in most accessible organs which are unsuitable for exfoliative cytology. Specimens obtained are smeared on glass slides and if recognizable pieces of tissue are present, they are processed as tissue biopsy specimens. In smears, it would be desirable to have the slides stained with Papanicolaou stain and one slide with the Wright-Giemsa stain. This technique has gained wide application in recent years in the United States and in competent hands is reliable and accurate. In the United States, due to the nature of medical practice, it is recommended that the technique be performed by a qualified clinician with the pathologist and his staff assisting to insure optimal samples. In Europe and in a few places in the United States, the practice of aspiration cytopathology is conducted entirely by a qualified cytopathologist including examining the patient and performing the aspiration cellular evaluation and often recommending management. It is used mainly for the diagnosis of primary and metastatic cancer when a mass is evident and for differentiating between benign and malignant lesions. In adequate samples, the histologic cell type of the tumor can be accurately evaluated. Histologic variants that can be reliably recognized will depend on the anatomic site of the specimen. Most histologic variants that can be recognized in tissue specimens can also be deduced in aspiration biopsy specimens. Organs or tissues in which aspiration cytology have been applied include lymph nodes, breast, lung, prostate, pancreas, liver, soft tissue, thyroid and bone. Data on most sites has been documented.[20,21] In competent hands this technique has reduced the number of open biopsies.

Summary

This presentation discusses some basic needs for providing a good diagnostic cytopathology practice as we know it today. It is hoped that the text together with the references in which more detailed information can be obtained will assist those who are intimately involved in using and providing service in this branch of anatomic pathology.

References are available from the author upon request.

• Dr. Ng., Jackson Memorial Hospital, 1700 N. W. 10th Avenue, Miami 33152.

The Diagnostic Value of Kidney Biopsy Brief Review

Victoriano Pardo, M.D.

An invasive procedure such as a kidney biopsy does not seem to be justified unless facilities for an adequate study of the tissue by light, electron and immunofluorescence microscopy are available.

We usually attempt to obtain two cores and the samples are divided as follows: the two tips (approximately 3 mms.) of the first biopsy are immediately immersed in fixative for electron microscopy. The remainder of the cylinder is left in a container with tissue culture media until the result of the second attempt is known. If a second core has been obtained, again the two tips are used for electron microscopy and the rest of the tissue for immunofluorescence. Then the first core left in tissue culture media is taken for light microscopy (Figure 1 upper area).

When the second attempt has been unsuccesful, the

remainder of the first biopsy still in culture media is hemisected lengthwise. Half cylinder is fixed for light microscopy and the rest is processed for immunofluorescence (Figure 1 lower left).

If only a small biopsy (less than 6-7 mms. in length) is available, it is sectioned lengthwise and a hemicylinder is taken for combined light and electron microscopy studies performed in plastic embedding and the other hemicylinder is processed for immunofluorescence (Figure 1 lower right).

For ultrastructural studies we prefer Karnovsky's[1] and for light microscopy Zamboni's fixative.[2] The latter may be used also for electron microscopy.

For immunofluorescence the tissue is embedded in aluminum boats containing OCT(R) which is snap frozen in liquid nitrogen. When the tissue has to be transported by mail we use Michel's fixative.[3] Upon receipt of the biopsy in Michel's fluid it is washed in Michel's buffer and processed as previously described for fresh tissue.

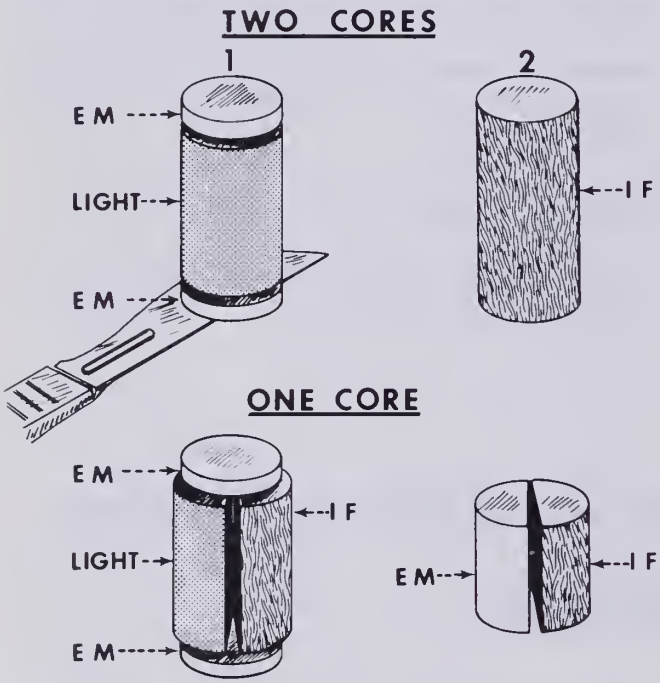


Fig. 1. Scheme representing the manner in which biopsy tissue is divided for study.

The Author

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Dr. Pardo received his medical degree in 1948 from the University of Havana. He received his pathology training at Massachusetts General Hospital, then practiced in Cuba. He returned to the United States and is now Professor of Pathology at the University of Miami School of Medicine and Director of the Renal Biopsy Unit at Jackson Memorial Hospital and the Veterans Administration Hospital, Miami.

If an open biopsy is contemplated it is important to request that in addition to a wedge, a needle biopsy be performed to sample deeper areas of the cortex. Arteritic lesions are most frequently evidenced in the deep interlobular or arcuate vessels and in focal and segmental glomerular sclerosis early lesions are also localized to the juxtamedullary areas.

Recent data on the pathogenesis of glomerular disease obtained through experimental models and the widespread use of electron microscopy and immunohistochemistry to study kidney biopsies have increased our ability to differentiate glomerular lesions and to identify etiopathogenic mechanisms.

Glomerular reactions to injury are limited, but the extent and type of glomerular involvement are clues to the nature of the disease.

By light microscopy, lesions may be designated as focal when only a few glomeruli are involved and generalized when most glomeruli are abnormal. If only a few lobules in each glomerulus are affected the term segmental is used as opposed to a diffuse lesion which extends to most of the area in each glomerulus (Figure 2). Since the extent of the glomerular damage correlates usually with the severity of the disease and has prognostic implications, this information is an important consideration in the evaluation of a biopsy report.

Several types of glomerular reaction may be identified. The terminology we shall use in this brief review is as follows: Proliferative glomerulonephritis-Increase in the number of cells manifested by an increase in nuclei. The proliferation may consist predominantly of epithelial cells (crescentic), capillary cells (intracapillary), mesangial cells (mesangial), and if the mesangial cells extend circumferentially along the capillary walls mesangiocapillary (membranoproliferative) glomerulonephritis (Figure 3). The term exudative is used for an increase in granulocytes in the capillary luminae and necrotizing glomerulonephritis describes fibrin deposition (fibrinoid) associated with desquamation of endothelial cells and denudation of the basement membrane.

Membranous glomerulopathy refers to a generalized and diffuse thickening of the glomerular basement membrane in the absence of proliferation. Segmental and focal basement membrane thickening associated with other types of glomerular pathology is not included under this name. Sclerosing lesions represent capillary basement membrane thickening and increase in mesangial matrix associated with capillary collapse and progressive obliteration of the loops with atrophy of the tufts.

The main contribution of electron microscopy has been the detection of changes in the capillary wall beyond the limits of resolution for the light microscope. The appearance and distribution of electron dense deposits have diagnostic implications. Large, irregularly distribut-

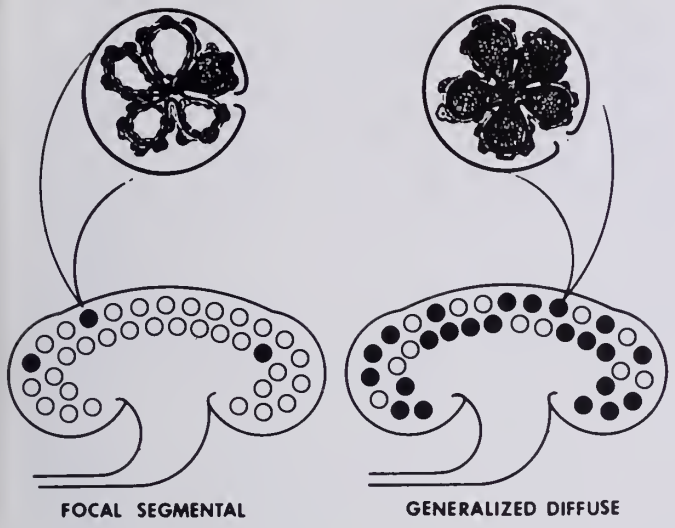


Fig. 2. Distribution of glomerular lesions in the kidney as a whole (focal or generalized) and within each glomerulus (segmental or diffuse).

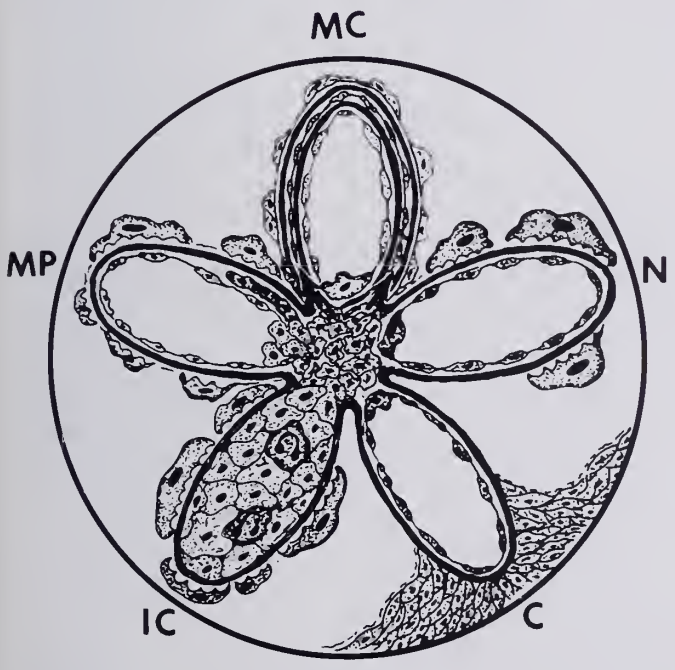


Fig. 3. Scheme of a normal glomerulus (N) to be compared with the following lesions arranged clockwise: epithelial proliferation or crescent (C), intracapillary proliferation and exudation (IC), increase of mesangial cells in mesangial proliferative glomerulonephritis (MP) and invasion of the peripheral loop by proliferating mesangial cells (arrows) in mesangiocapillary glomerulonephritis (MC).

ed subepithelial deposits "humps" are suggestive of a post-infectious glomerulonephritis (Figure 4 B). Smaller, more regular subepithelial deposits are typical for membranous glomerulopathy (Figure 4 C). Subendothelial dense deposits along the inner contour of the basement membrane are suggestive of S.L.E. (Figure 4 D). Predominatly mesangial deposits are seen in primary benign recurrent hematuria, S.L.E. and Schonlein-Henoch patients (Figure 11). Splitting of the lamina densa with intervening osmiophilic granules appears to be the hallmark of Alport's syndrome[4] (Figure 4 E).

Immunofluorescence studies contribute to identify the nature of the substance present in glomerular deposits. In addition these may give clues as to the pathogenesis of the disease. Antiglomerular basement membrane disease (as seen in Goodpasture's syndrome) displays linear deposits while immune-complex glomerulonephritis has a granular appearance (Figure 5). As with light microscopy, in the study of biopsies it is important to determine the extent (focal or generalized) and localization (mesangium or peripheral loop) of the lesions.

We will refer now to the most frequent characteristic biopsy findings in the nephrotic syndrome, in instances of nephritic syndrome and in patients with recurrent gross or microscopic hematuria. Finally, we shall consider the renal involvement in a systemic disease such as lupus erythematosus and in membranoproliferative (mesangiocapillary) glomerulonephritis, a pathological entity with a typical light microscopy appearance.

I-NEPHROTIC SYNDROME

Patients exhibit edema, hypoalbuminemia, hyperlipidemia and overt proteinuria (more than 3.5-5 gms in 24 hrs.).

The most frequent cause of the nephrotic syndrome in childhood is minimal lesion lipoid nephrosis (80-90%) followed by focal and segmental glomerular sclerosis (5-10%). In adults membranous glomerulopathy predominates.

1) Minimal lesion "lipoid nephrosis":.[5]

In minimal lesion disease the glomeruli appear normal by light microscopy (Figure 6 A) and by immunofluorescence there are no deposits. Electron microscopy shows swelling of the epithelial foot processes (Figure 6 B) but this lesion is not specific since it may be observed in any renal disease associated with proteinuria.

The peak incidence is at 2-3 years of age. Most patients respond to steroid therapy and although relapses are common the majority are free of disease on long term follow up.

There is no evidence for an immunologic etiopathogenic mechanism although the disease is sometimes preceded by a respiratory infection or prophylactic

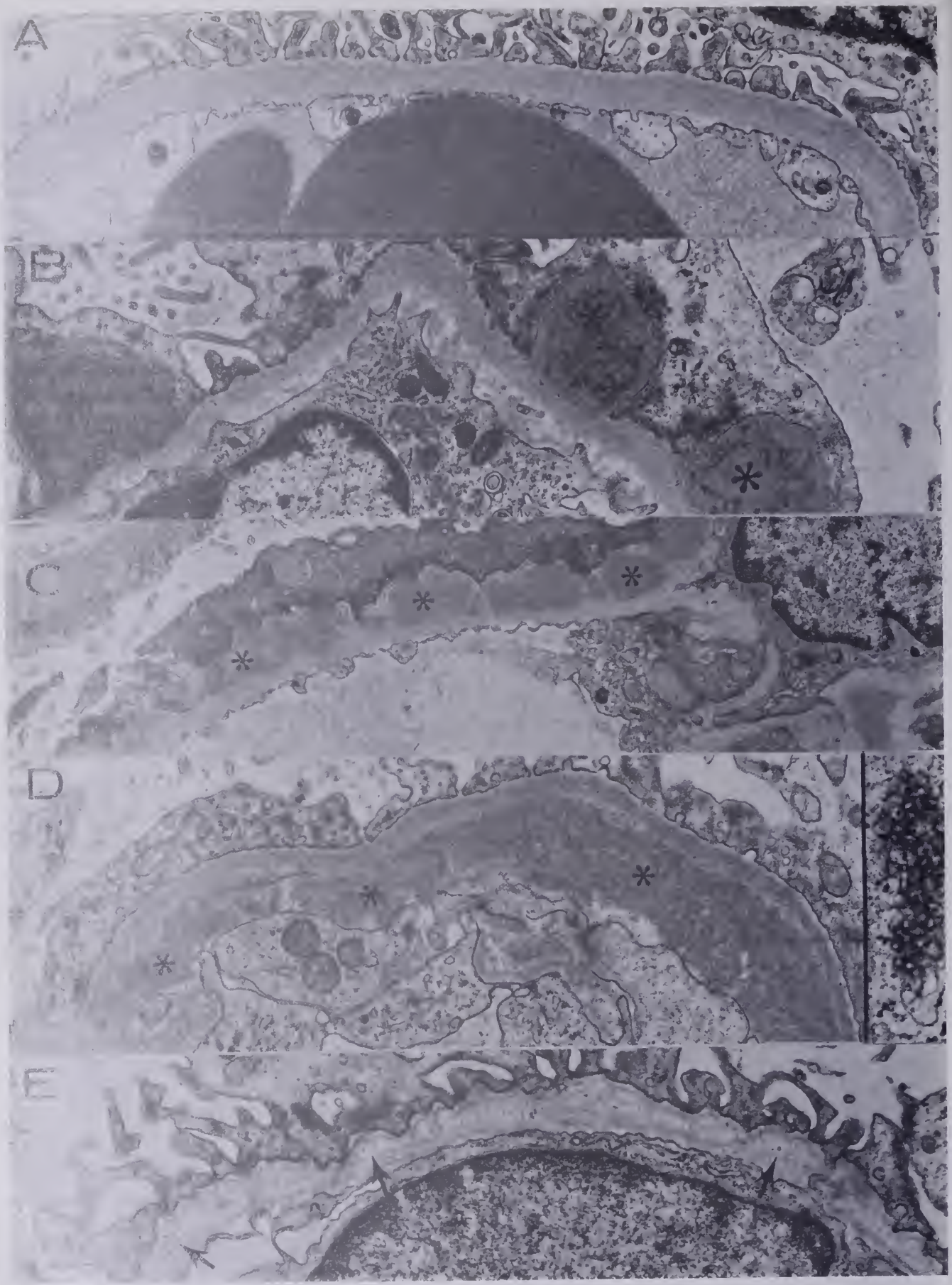


Fig 4 Ultrastructure of the capillary wall in characteristic lesions (A) Normal glomerulus is included in the top for comparison. (B) Subepithelial deposits or "humps" (asterisks) in post-infectious glomerulonephritis. (C) More regularly arranged subepithelial deposits on a thickened lamina densa in membranous glomerulopathy. (D) Subendothelial deposits in S.L.E. Inset-tubuloreticular endothelial cytoplasmic inclusions. (E) Splintering and splitting of the lamina densa with intervening osmiophilic granules in hereditary nephritis (Alport's syndrome).

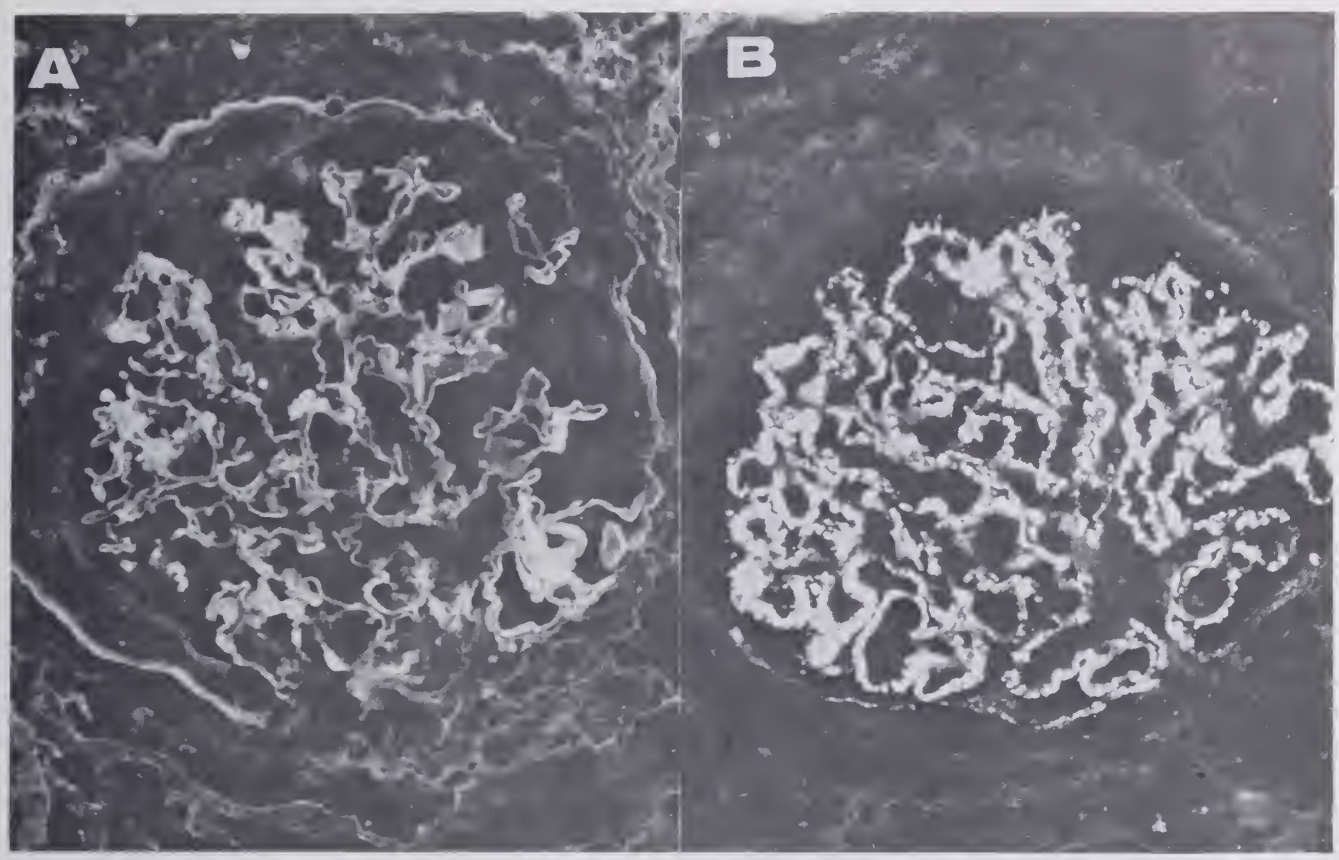


Fig. 5. —(A) Linear deposits of immunoglobulin G in a patient with anti-glomerular basement membrane nephritis (Goodpasture's syndrome) and (B) granular deposits in immune complex nephritis (membranous glomerulopathy).



Fig. 6. (A) Normal glomerulus by light microscopy in minimal lesion lipoid nephrosis. (B) Swollen epithelial foot processes by EM. Normal width of a foot process is represented by the open rectangle.

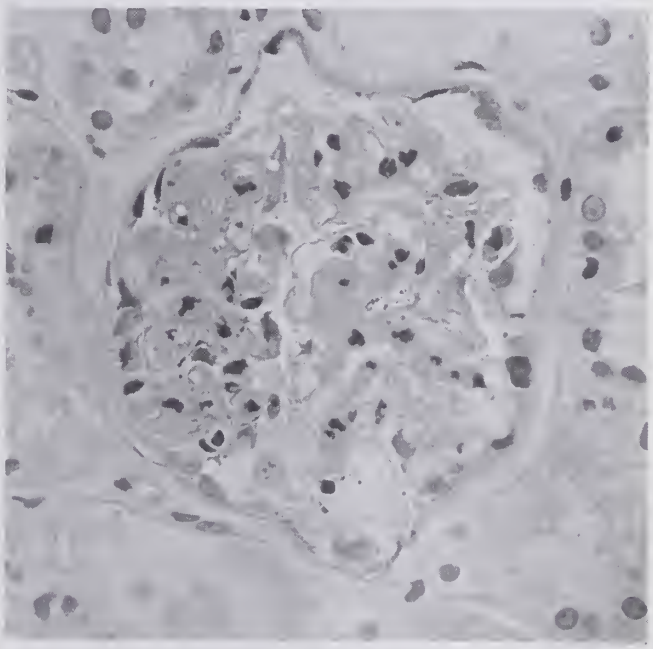


Fig. 7. Glomerulus displays sclerosis, foam cells and an adhesion involving the left half of the glomerular tuft.

immunization. However, some patients with lipoid nephrosis present increases in IgM serum levels[6] and the possibility that T lymphocyte lymphokines may damage the glomerular basement membrane has been raised.[7]

The ultrastructural basis for the increase in protein excretion is not well understood. Experimental studies have evidenced a disappearance of the polyanion layer surrounding the epithelial foot processes in nephrosis,[8] leading to an increased permeability for similarly charged molecules.

2) Focàl and Segmental glomerular sclerosis:.[9]

Only a few glomeruli are involved at the onset of the disease. Changes consist of progressive increase in mesangial matrix and capillary collapse associated with sclerosis of the loops of one or several lobules. Segmental adhesions are related to these lesions (Figure 7). Proliferation is absent or limited to some increase in mesangial nuclei or epithelial cells in the areas of adhesions. Foam cells may be also present as well as intracapillary acidophilic deposits (hyalinosis).

Progress of the glomerular lesion is associated with an increase in interstitial fibrous tissue, tubular atrophy, and eventual development of renal failure. Immunofluorescence examination shows focal and segmental deposits of IgM and C3 in similar distribution to the light microscopy lesions. Glomeruli not involved by focal sclerosis may show hyperplasia of mesangial cells and this finding of mesangial hyperplasia in children with apparently minimal lesion disease may arise the suspicion that a focal lesion was missed by the needle biopsy. The juxtamedullary glomeruli are predominantly affected.

The presence of the juxtamedullary region of the kidney in the biopsy should be ascertained since early lesions are usually circumscribed to this area. The recurrence of the disease in renal transplants supports a systemic etiopathogenesis.

3) Membranous glomerulopathy:[10,11]

In early stages the capillary basement membrane thickening is equivocal and EM may be necessary to make the diagnosis through the demonstration of the typical subepithelial electron dense deposits or also the identification of granular deposits of IgG by immunofluorescence. In later stages of the disease with diffuse thickening of the capillary wall by LM (Figures 8 and 4C) the lamina densa appears progressively thicker and the deposits may move to an intramembranous location.

Membranous glomerulopathy is the most frequent cause of the nephrotic syndrome in adults and although the vast majority of cases are idiopathic, recent studies have demonstrated the etiopathogenic role of some antigens. Infectious agents, drugs, and endogenous (tumors) as well as autogenous antigens (renal tubular epithelial antigen) have been incriminated and some of these antigens demonstrated in the glomerular deposits

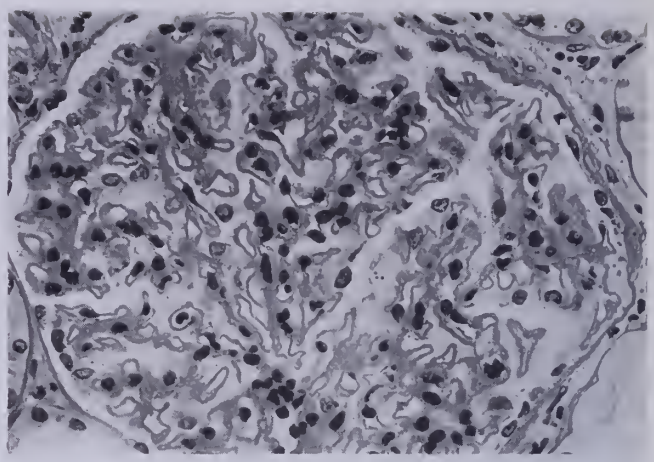


Fig. 8. Diffuse basement membrane thickening in membranous glomerulopathy.

as well as the corresponding antibodies obtained by elution from kidney tissue. The importance of identifying the antigen is obvious since withdrawal or elimination of the offending substance (e.g., gold) or treatment of the infectious disease (malaria, syphillis) may result in cure of the disease if started in the early stages.

The lesion probably results from continuing recurrent invasion of the blood stream by small amounts of low avidity antibodies.

Patients with mild proteinuria or asymptomatic proteinura and membranous glomerulopathy appear to have a better preservation of renal function and prognosis than those with nephrotic syndrome, particularly when the latter is refractory to treatment. About 70% of the patients may have preserved renal function after 5 year follow-up and 20% are in remission. Children have a better prognosis than adults. The effects of treatment seem questionable since the number of induced remissions does not exceed spontaneous remissions of the nephrotic syndrome. Renal vein thrombosis may complicate MG and in the majority of instances it seems to be secondary to the parenchymal process.[12]

Other less frequent causes of the nephrotic syndrome with characteristic biopsy findings in adults are diabetes and amyloidosis.

In diabetes there is a diffuse thickening of the capillary wall and mesangium which is identified by LM or the lesions may predominate in the mesangium (nodular diabetic glomerulosclerosis). In late onset diabetes diagnosis may be difficult on clinical grounds alone because the manifestations of diabetes may be subclinical.

Amylodiosis also shows predominant mesangial involvement with a characteristic EM picture of 200 Å diameter fibrills. Small lesions may be difficult to detect or

equivocal by light microscopy, even with the use of special stains.

II. NEPHRITIC SYNDROME

1) Post infectious glomerulonephritis:[13]

By light microscopy there is usually a proliferative and exudative lesion (Figure 9) electron microscopy shows subepithelial dense deposits "humps" (Figure 4 B) and immunofluorescence granular deposits of IgG and C3 in an irregular distribution and size. The deposits diminish in the late stages of the disease and are generally absent if the biopsy is performed later than six weeks since the first clinical manifestations of the infectious disease. The presence of a few crescents does not seem to modify the prognosis.

Post-streptococcal glomerulonephritis is the prototype of this syndrome. The disease appears after an incubation time of 10-12 days following infection. Shorter incubation periods suggest a reactivation of a chronic renal lesion. In the South, impetigo is a more frequent cause of the disease than pharyngitis. Increasing serial determinations of antibodies to Streptococcal components are important for the diagnosis and high antihyaluronidase and antideoxyribonuclease B titers instead of ASO titers are associated with the disease in skin infections. Complement C^3 levels are low during the acute stages.

There is resolution without sequalae in 95-98% of children in epidemics while in adults with endemic disease the percentage is lower (60-70%). Genetically determined host factors may influence susceptibility to the disease.

Although strong epidermiological evidence implicates the streptococcus as the offending agent, the demonstration of streptococcal antigen in the glomerular lesions is controversial.

Similar histologic lesions and renal clinical manifestations may be also encountered after staphylococcal, pneumococcal or viral infections or in association with subacute bacterial endocarditis, thus the term post-infectious seems more appropriate for this lesion. However, it is important to establish the streptococcal etiology through bacteriological and serological tests since the renal disease is more benign in instances of streptococcal associated lesions.

Treatment is supportive. Sediment abnormalities may be present for long periods of time up to one year or more and histological resolution frequently lags behind clinical recuperation.

2) Crescentic glomerulonephritis:[14]

Predominant epithelial cell proliferation with obliteration of the uriniferous space is seen (Figure 10). The clinical manifestations of a rapidly progressive glomerulonephritis are usually present only when the majority of the glomeruli (+than 70-80%) are involved. Fibrin deposits

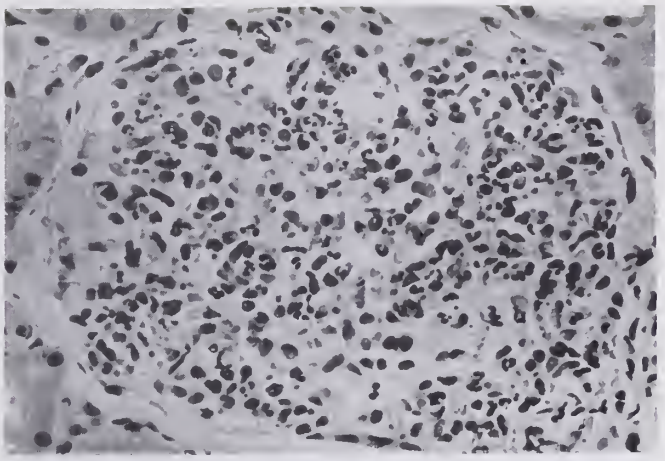


Fig. 9. Post-infectious glomerulonephritis. Capillary luminae are obliterated by the increase in swollen and proliferated intracapillary cells. Numerous granulocytes are seen.

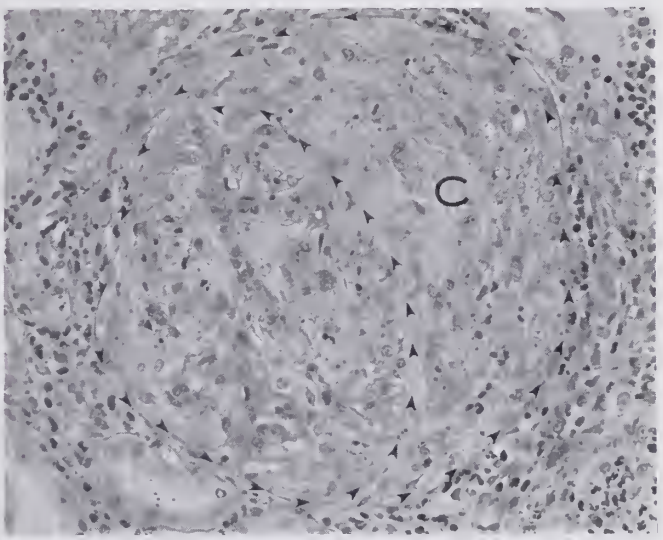


Fig. 10. Epithelial cell proliferation (Crescent-C) occupies most of the glomerular space. The tuft is compressed to one side.

appear to play a role in the pathogenesis of the lesions and some of the cells in the crescents may be originally monocytes.

Although most cases are idiopathic, the etiopathogenesis can be suspected in some instances. A post-streptococcal etiology may be suggested by the typical subepithelial deposits "humps" on EM examination. Immunofluorescence may identify the lineal deposits encountered in Goodpasture's syndrome. Polyarteritis frequently results in crescentic lesions and the necrotizing arteritis may be missed in the biopsy study. Other diseases exhibiting also crescentic lesions are Wegener graulomatosis and S.L.E. In Wegener's the presence of granulomatous lesions and arteritis aid in the diagnosis.

S.L.E. presents frequently subepithelial and subendothelial dense deposits.

Establishing these diagnoses is important for an early adequate treatment. In Goodpasture's syndrome early plasmapheresis may bring about improvement. In Wegener's granulomatosis cytoxan treatment has been efficient. Steroids are indicated in polyarteritis and S.L.E.

Glomerular deposits are absent in approximately 30% of the biopsies with crescentic lesions suggesting that some cases may not be related to an immune complex pathogenesis.

III. RECURRENT PRIMARY HEMATURIA (ASYMPTOMATIC, IDIOPATHIC) [15,16]

These patients present with gross or microscopic, recurrent or persistent hematuria, as the predominant manifestation in the absence of respiratory or genitourinary disease.

Benign primary hematuria designates the majority, who exhibit minimal or absent proteinuria and do not show hypertension or any other evidence of renal disease. There is no deterioration of renal function, at least during a follow up period of 5 to 10 years, although hematuria persists in approximately 50% of the cases.

At biopsy glomeruli appear normal or there may be mesangial proliferation (more than 3 nuclei in a mesangial area) (Figure 11 A) Mesangial electron dense deposits may be seen in 25% of the patients (Figure 11 B) and mesangial deposits of immunoglobulins or complement C3 in sixty five percent (Figure 11 C). IgA and IgM are the predominant immunoglobulins.

Mesangial deposits of IgA may be also demonstrated in a smaller group with progressive renal disease, that displays segmental areas of intracapillary proliferation and sclerosis or adhesions (progressive IgA nephropathy). These patients have a twenty four hour protein excretion over 1 gm and may manifest hypertension or renal insufficiency.

Although the terms IgA nephropathy (Berger's disease) and focal glomerulonephritis have been used to identify these conditions this designation has led to confusion since there is not a consistent correlation between these biopsy findings and the clinical presentation or outcome.

Because identical light, EM and IF changes may be observed in other renal diseases such S.L.E. and Schonlein-Henoch purpura, the diagnosis rests also on a detailed clinical and laboratory evaluation to rule out other causes of hematuria.

Radiologic examination may be necessary in children to exclude genitourinary lesions and in adults cystoscopy to exclude a possible bladder tumor when patients have negative or atypical biopsy findings.

The good correlation between clinical presentation and minimal histologic lesions in patients with benign primary hematuria suggests that kidney biopsy may not be indicated in most instances of benign primary hematuria unless there is an increase in urinary protein excretion or other manifestation of renal involvement on follow up. On the other hand, it may help to establish the glomerular source of bleeding, in instances that simulate genitourinary lesion.

IV. RENAL INVOLVEMENT IN SYSTEMIC DISEASES

Systemic lupus erythematosus is the most frequent systemic disease involving the kidney. The immune complex pathogenesis has been well documented. Immunoglobulins, complement and DNA as antigen have been demonstrated in the glomerular lesions. In addition, eluates from the lesions possess antinuclear activity.

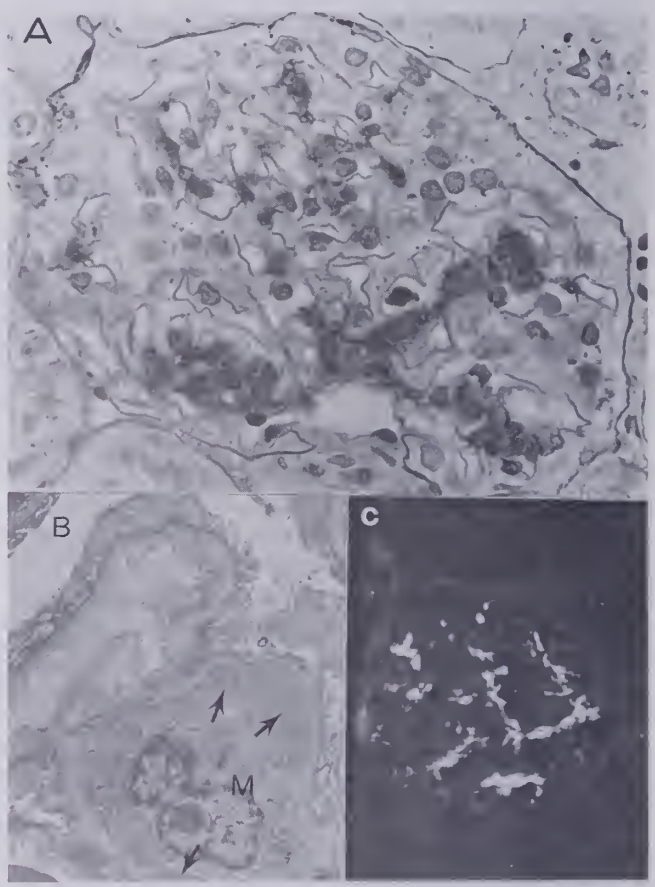


Fig. 11. Patient with benign primary hematuria. (A) Glomerulus exhibits three mesangial areas with an increase in matrix and nuclei. (B) Electron microscopy of same patient to show paramesangial dense deposits (arrow). (C) Immunofluorescence evidences deposits of IgA in the mesangial stalks.

The disease displays protean clinical and histologic presentations. This may be related to the physicochemical characteristics of the immune complexes formed in the circulation and deposited in the kidney. Paralleling the experimental studies, it appears that complexes in antibody excess localize in the mesangium, those in slight antigen excess lead to a diffuse proliferative change and small amounts of a recurrent production of low avidity antibodies form complexes that result in a membranous lesion. Four clinically significant lesions of lupus nephritis may be recognized:[17, 18]

1) Mesangial proliferative glomerulonephritis: These patients may simulate instances of benign primary hematuria since they present with microscopic hematuria, mild proteinuria and normal renal function. By electron microscopy dense mesangial deposits are seen and immunofluorescence demonstrates mesangial deposits of immunoglobulins.

2) Focal proliferative glomerulonephritis: Only a few glomeruli exhibit intracapillary proliferation with occasional exudative and even necrotizing lesions (Figure 12). There is an abnormal urine sediment but no progression to renal insufficiency.

3) Diffuse proliferative glomerulonephritis: Lesions are diffuse and generalized and frequently there are segmental adiophilic "wire loop" lesions and adhesions (Figure 13). Hypertension may be present as well as changes in renal function.

4) Membranous glomerulopathy: Glomerular abnormalities and clinical manifestation are identical to those encountered in the idiopathic variety of membranous disease. The presence of mesangial hyperplasia favors a diagnosis of S.L.E.

By IF, all these different groups display mesangial and capillary wall deposits of immunoglobulins and C3 complement as well as other complement fractions suggestive of activation of the alternate pathway.

By EM subendothelial deposits support a diagnosis of S.L.E. (Figure 4 D) and are considered to represent activity in contrast with intramembranous or subepithelial deposits which represent a more chronic process. Tubuloreticular structures on the cytoplasm of endothelial glomerular cells, previously considered viral inclusions, are seen frequently in lupus patients (Figure 4 C inset).

Since there is not a consistent correlation between the clinical presentation and the histology, kidney biopsy may be necessary to guide treatment. High doses of steroids and immunosupressive treatment may be required in instances of diffuse lupus nephritis, a treatment that represents an unnecessary risk in other lesions.

Low complement levels and high DNA binding are manifestations of activity which may help in the management of these patients.

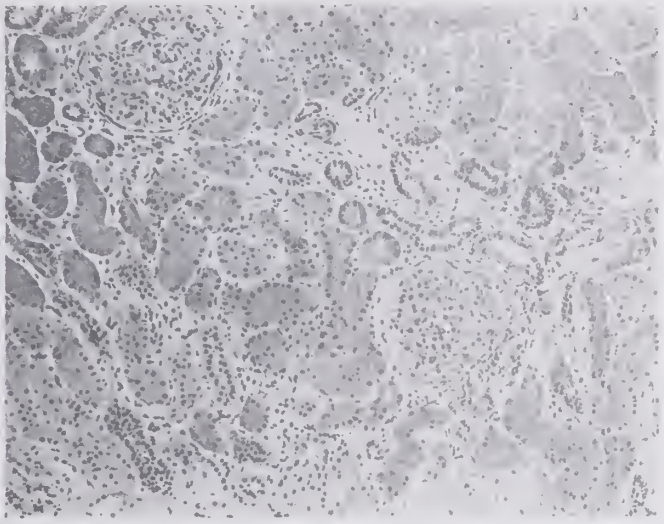


Fig. 12. Focal S.L.E. biopsy presents only one segmentally affected glomerulus (upper left). There are no other parenchymal lesions.

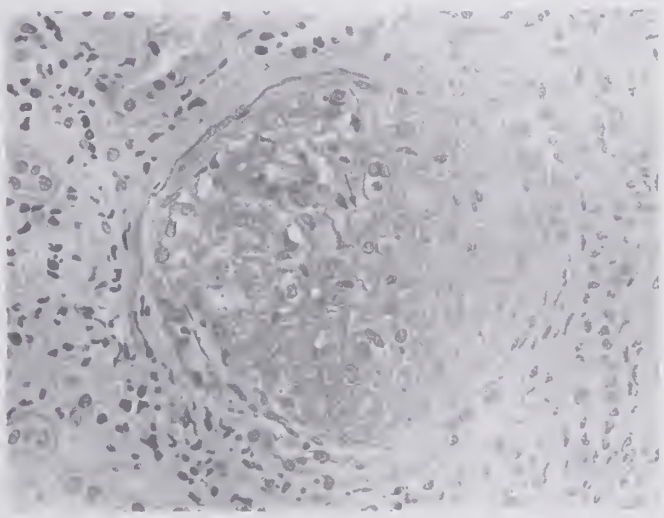


Fig. 13. Extensive glomerular involvement in diffuse lupus nephritis. Segmental thickening of the capillary basement membrane "wire loop" is seen at arrow.

V. MESANGIOCAPILLARY GLOMERULONEPHRITIS (MEMBRANOPROLIFERATIVE GLOMERULONEPHRITIS)[19]

This histologic lesion was so designated because by light microscopy mesangial proliferation is associated with capillary basement membrane thickening. Electron microscopic studies have contributed to the identification of the latter as a peripheral circumferential extension of proliferating mesangial cells, thus the term mesangiocapillary appears more descriptive. With PAS or silver stains the peripheral basement membrane appears split ("double contour") (Figure 14 A). Crescents may be seen in some biopsies and are usually associated with a bad prognosis.

FINDINGS AND CHARACTERISTICS OF RENAL DISEASES STUDIED BY RENAL BIOPSY

TABLE I

NEPHROTIC SYNDROME	AGE	LIGHT MICROSCOPY	ELECTRON MICROSCOPY	IMMUNO FLUORESCENCE	CLINICAL FEATURES	TREATMENT
MINIMAL:	Mostly (90%) children 2-6 years of age	Normal	Swollen epithelial foot processes	Negative	May relapse but healing is usual	Responds to steroids
FOCAL SCLEROSIS:	About 8% children 8-12 years of age	Focal and segmental sclerosis. Hyalinosis	Not characteristic	Segmental and focal IgM and C3	Eventual renal failure. Recurs in transplants	No response to steroids
MEMBRANOUS:	Adults	Diffuse and generalized basement membrane thickening	Subepithelial deposits	Diffuse and generalized granular capillary wall deposits of IgG and C3	Slow development of renal failure. Important to identify antigen (Exogenous, endogenous, autogenous).	Idiopathic poor response. If antigen known specific treatment.
DIABETES:	Adults	Diffuse mesangial or capillary wall thickening Nodular mesangium	Increase in basement membrane or mesangial material	May exhibit focal and segmental IgM and C3	May appear in patients with asymptomatic diabetes	Treatment of diabetes
AMYLOIDOSIS:	Adults	Wide mesangium Congo red and birefringent	200 A fibrils without periodocity	IgG present in paraprotein-related amyloidosis (primary)	Associated disease chronic infections or paraprotein	Melphalan
NEPHRITIC SYNDROME						
POST-INFECTIOUS: (Post-Streptococcal)	Predominantly children	Intracapillary proliferative and exudative glomerular lesions	Subepithelial depoaits ("Humps")	Diffuse and generalized granular deposits on the capillary wall of IgG & C3.("lumpy-bumpy")	High anti-strep antibody Low C3. Good prognosis: Children+Epidemic. 20% Chronic: Adults+Endemic Streptococcal etiology better prognosis	Supportive
CRESCENTIC:						
1) IDIOPATHIC	Adults	Crescents	Fibrin	Negative or granular deposits IgG	Rapidly progressive if crescents are present in more than 75% of glomeruli	Rapid renal failure-dialy
2) POST-INFECTIOUS	Children	Crescents	Fibrin + subepithelial deposits	Diffuse generalized granular IgG+C3 capillary wall	Better prognosis than idiopathic	Supportive dialysis
3) GOODPASTURE'S SYNDROME	Adults	Crescents	Fibrin	Linear IgG	Anti-glomerular basement membrane antibodies in serum. Pulmonary hemorrhage	Dialysis Plasmapheres
4) POLYARTERITIS	Adults	Crescents Necrotizing arteritis	Fibrin	Fibrin	Systemic manifestations	Steroids
5) WEGENER'S GRANULOMATOSIS	Adults	Crescents arteritis granulomas	Fibrin	Fibrin	Associated upper respiratory manifestations	Immuno-suppressive
RECURRENT HEMATURIA:						
1) BENIGN PRIMARY HEMATURIA	Young adults	Mesangial with increased matrix and cells	Mesangial deposits	Mesangial deposits Ig's or C3	Protein excretion under 1 gm in 24 hours urine. No hypertension	Good prognos No treatmen
2) PROGRESSIVE Ig A NEPHROPATHY	Older	Mesangial matrix and cells. Intracapillary proliferation adhesions	Mesangial and peripheral loop deposits	Mesangial and peripheral loop IgA	Increase of protein in 24 hour urine + IgM hypertension. Recurrence in trans-plant	Supportive Develop ren failure
NEPHROTIC-NEPHRITIC SYNDROME						
MEMBRANO-PROLIFERATIVE (MESANGIOCAPILLARY)						
1) TYPE I	Children	Mesangial proliferation with peripheral extension to capillary walls	Subendothelial deposits	Granular, generalized diffuse mesangial and capillary wall IgG & C3	Hematuria and nephrosis	Poor respon steroids
2) TYPE II Dense deposit disease	Children	Mesangial proliferation not as prominent as in Type I	Ribbon-like intra-membranous very dense deposits.	C3 in segments of capillary wall	Marked low C3 C3NeF in serum Recurrence in transplants	Poor repons steroids

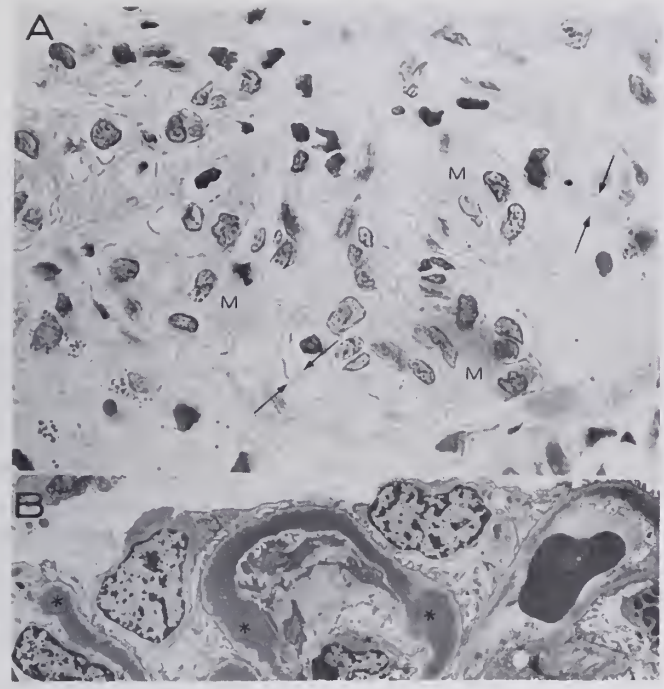


Fig. 14. (A) Mesangial increase in nuclei and matrix (M) and splitting of the capillary basement membrane (arrows) in mesangiocapillary glomerulonephritis type I. (B) Type II mesangiocapillary glomerulonephritis with extensive dense deposits (asterisks) in the basement membrane.

Electron microscopy demonstrates that the apparent splitting of the basement membrane results from a newly formed basement membrane (lamina densa) appearing between the advancing mesangial cells and the endothelium that is displaced towards the capillary lumina. Two types of lesions may be distinguished. In Type I there are subendothelial dense deposits and Type II displays dense intramembranous ribbon like deposits (Figure 14 B). The latter is associated more frequently with overt hypocomplementemia, C3 complement predominates in the deposits and the disease may recur after transplantation.[20]

Older children and adults are affected and there is a wide variation in clinical presentation. Edema, hematuria and hypertension are common. Abnormalties in a variety of complement components have been encountered as well as the presence of a C3 nephritic factor but the decrease in C3 levels in the serum is sufficient in most patients to demonstrate the complement abnormalities and is available in most clinical laboratories.

Similar mesangiocapillary lesions have been observed also in sickle cell anemia and in partial lipodystrophy. In the latter, complement abnormalties may even precede the development of renal lesions. A beneficial effect of steroid or immunosupressives has not been proved.

VI. CHRONIC SCLEROSING GLOMERULONEPHRITIS

Glomerular changes consist fundamentally of sclerosis and collapse of the capillary loops associated with extensive interstitial fibrosis and tubular atrophy. It is the most common cause of chronic renal failure and represents the final anatomic pathway of all types of glomerulonephritis. In some patients a history of an acute episode of glomerulonephritis may be obtained but in the majority the disease appears to follow a subclinical smoldering course, frequently asymptomatic, until the functional reserve of the kidney is exhausted and there are no clues as to the initial pathologic process.

Renal biopsy is also useful in the diagnosis of acute interstitial nephritis and acute renal failure. In acute tubulo-interstitial nephritis there is interstitial edema and an inflammatory infiltrate consisting of lymphoplasmocytic cells and granulocytes. Some of the latter are frequently eosinophils. The lesion may be confused with an acute interstitial nephritis secondary to infection (acute pyelonephritis) but in the latter the infiltrate consists virtually of pure neutrophilic granulocytes.

In acute vasomotor nephropathy (acute tubular necrosis) necrosis of tubular cells is seldom seen. Interstitial edema and tubular dilatation are sometimes the only abnormalities. There may be changes in the staining pattern of tubular cell nuclei and desquamation of the tubular cells. In some instances the diagnosis is one of exclusion because glomerular lesions are absent in association with acute renal failure.

References are available from the author upon request.

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Histiocytoid Hemangioma

A proposal of a new entity which embraces previously described diseases of heart, blood vessels, skin, bone and other sites

Juan Rosai, M.D.

Over the course of the past few decades, a relatively large number of entities have been described in many locations, characterized by the proliferation of endothelial cells of blood vessels and sometimes accompanied by an inflammatory infiltrate rich in eosinophils. These entities have been regarded as separate and there has been some argument as to whether they represent a hyperplastic or neoplastic phenomenon, depending on their location, behavior and appearance. These entities include a skin disorder variously called angiolymphoid hyperplasia with eosinophilia, pseudopyogenic granuloma and atypical vascular proliferation with inflammation; a lesion of blood vessels that has been reported with the descriptive term of intravenous atypical vascular proliferation; most cases of bone tumors that have been reported as low-grade angiosarcoma or hemangioendothelioma; and an extremely rare condition of the heart that was described many years ago as endocardial benign angioreticuloma. After reviewing the literature on the subject and examining by light microscopy, histochemistry, and electron microscopy some personal cases of this disorder, we have reached the conclusion that they all represent different manifestations of the same entity, which we propose to designate as *histiocytoid hemangioma*.[2] The common denominator of all of these lesions is the proliferation of cells which have the basic features of an endothelial cell but which also exhibit histochemical and ultrastructural characteristics that are more akin to those of a histiocyte.

The studies of Eady et al[1] on a series of 4 cutaneous cases of this condition showed that these cells exhibit marked histochemical and ultrastructural differences with normal endothelial cells. Instead of the high alkaline phosphatase activity and low level of non-specific esterase, acid phosphatase and respiratory enzymes characteristic of the endothelium of normal capillaries, these "extraordinary" cells showed a negative alkaline phosphatase reaction (both by the Gomori lead phosphate and the azo-dye method) and a very intense positivity for nonspecific esterase, acid phosphatase, dehydrogenase, glucose-6-phosphate dehydrogenase, cytochrome oxidase and NADH diaphorase. Ultrastructurally, the cells were separated by extensive gaps, alternating with areas of interdigitation and intercellular tight junctions. Their cytoplasm contained prominent 100 to 150 Å cytofilaments and bundles of finer filaments associated with dense bodies; occasional microbodies were also observed. A notable feature of the cytoplasm was the presence of large membrane-bound vocuoles, either single or multiple. Weibel-Palade bodies (a characteristic albeit not pathognomonic cytoplasmic marker of endothelial cells) were sparse, particularly in



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Dr. Rosai is a native of Italy who emigrated with his family to Argentina in 1948. He received his M.D. degree from the University of Buenos Aires in 1961. He trained in Pathology at Regional Hospital in Mar del Plata, and at Barnes Hospital, St. Louis, Mo. From 1967 to 1974, he was a member of the staff of the Division of Surgical Pathology at Washington University. In 1974 he was appointed to his present position as Professor of Pathology and Director of Anatomic Pathology and Surgical Pathology at the University of Minnesota Medical School. Dr. Rosai is author of more than 70 articles on anatomic and surgical pathology, the 6th Edition of the book "Ackerman's Surgical Pathology" (to be published this year), the second series of the AFIP Fascicle on Tumors of the Thymus (in collaboration with Dr. Gerald D. Levine) and the chapter on "Tumors and Tumorlike Conditions of the Bone" in the 7th Edition of the book "Pathology," edited by Drs. W. A. D. Anderson and J. M. Kissane.

Table I

Diseases Included in the Spectrum of Histiocytoid hemangiomas

Skin, oral cavity, anditory canal and penis

Angiolymphoid hyperplasia with eosinophilia
Subcutaneous angioblastic lymphoid hyperplasia with eosinophilia
Pseudo or atypical pyogenic granuloma
Papular angioplasia
Inflamrnatory arteriovenous hemangioma
Inflammatory angiomatoses
Atypical vascular proliferation with inflammation
Some reported cases of cutaneous angiosarcoma and Kaposi's sarcoma

Large Vessels

Intravenous atypical vascular proliferation
? Some reported cases of angiosarcomas of vessels

Soft tissue

"Epithelioid" hemangioma
Some reported cases of hemangioendothelioma and angiosarcoma

Spleen

Some reported cases of hemangioendothelioma

Bone and periosteum

Many (? most) reported cases of angioendothelioma, hemangioendothelioma and low grade angiosarcoma

Heart

Endocardial benign angioreticuloma

Table II

Diseases not Included in the Spectrum of Histiocytoid Hemangiomas

Kimura's disease of the Orient
Masson's "vegetant intravascular hemangioendothelioma"
Intravascular papillary endothelial hyperplasia
Pyogenic granuloma with recurrent satellites
Intravenous pyogenic granuloma
Proliferating angioendotheliomatosis
True angiosarcoma of skin, soft tissue, large vessels, bone and other organs
Malignant endovascular papillary angioendothelioma

the larger cells. A basal lumina was present on the side opposite to the lumen; it was thin, fragmented and sometimes multilayered. These unusual features could be the expression of a morphologic abnormality or represent an overgrowth of a specific and as yet undefined subpopulation of endothelial cells, such as Majno's "contractile endothelial cell."

We have recently seen the same condition in other locations, such as oral cavity, external ear canal, penis, soft tissue and spleen. We have also seen an example of what probably represents the lymph vessel counterpart of this lesion in the spleen. Whether this group of proliferative diseases is of a reactive or neoplastic nature is not immediately apparent, although the latter is favored. However, it is clear that the behavior of these lesions, as a group, is quite indolent and even self-limited, in contrast to the aggressive behavior and often fatal outcome of the true angiosarcomas that they so closely resemble on microscopic grounds.

References are available from the author upon request.

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Vesiculobullous Lesions of the Skin, a Simplistic Approach to Diagnosis Based Solely on Microscopic Findings

Eugene H. Ruffolo, M.D. and J. Lincoln Tamayo, M.D.

The diagnosis and treatment of vesiculobullous diseases make up a significant part of dermatologic practice. The astute clinician has usually narrowed down the diagnostic possibilities to a few diseases before he performs a biopsy. Proper biopsy, accompanied by an adequate clinicopathological correlation, will usually enable the pathologist to make his final conclusions without too much difficulty. This is an ideal situation; unfortunately, it is not always the case. Pathologists who work in laboratories that receive biopsies from offices of busy general surgeons, general practitioners, plastic surgeons, and a myriad of other subspecialties, often receive biopsies elegantly submitted as "back", "forearm", or just as "blister." This is, indeed, a challenge to any of us, and most especially to the inexperienced pathologist who has just completed his university program in which he has been exposed to nothing less than mesangiocapillary glomerulonephritis and related conditions. He has not been prepared, in most situations, for this type of practice to which he refers disparagingly as "skin nits."

If one has a rather organized approach to the diagnosis of vesiculobullous disease, he can diagnose, or at least suggest a few pertinent possibilities. At that time, a phone call to the clinician and a few pointed questions such as, "Where is it from?", "Does it itch?", "How long has it been there?", "Are the blisters in groups? Recurrent? Where are they located?" and, finally, "What do you think it is?" will usually suffice to conclude his investigation.

Vesicles and bullae (less or greater than 0.5 cm) are customarily classified as: subcorneal, intradermal, and subepidermal, with a few subcategories (Table I). There are about a dozen conditions which can be placed very comfortably in these categories which will encompass the vast majority of encountered cases.

I. Subcorneal vesicles.

1. Subcorneal pustular dermatosis

The vesicle is located beneath the corneal layer and found within the vesicles are polys, occasional eosinophils, and a rare acantholytic cell (Figure 1). The differential diagnosis from impetigo is usually not possible without demonstration of bacteria by means of a Gram stain. It is important to note that the line of cleavage is immediately under the horny layer.



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Dr. Tamayo attended medical school at the University of Madrid and the University of Havana. He interned at Muhlenberg Hospital in Plainfield, N.J., and took residency training in Pathology at Orange Memorial Hospital, Orlando, and Tampa General Hospital, Tampa. He was in practice at Wuesthoff Memorial Hospital in Rockledge from 1967 to 1969, and since 1970 he has practiced at Tampa General Hospital.

EUGENE H. RUFFOLO, M.D.

Dr. Ruffalo received his medical degree at Georgetown University in 1949. Following internship and residency training in Obstetrics and Gynecology at St. Mary's Hospital in New York, he served with the U.S. Navy in Jacksonville and Naples, Italy, until 1958. He received a Fellowship in Pathology at the Mayo Clinic in Rochester, Minn., where he resided until 1962, when he began practice at Tampa General Hospital.

Table I.

I. Subcorneal vesicles.
   1. Subcorneal pustular dermatosis
   2. Impetigo

II. Intraepidermal vesicles.
   A. Acantholytic disorders
      1. Pemphigus vulgaris
      2. Hailey-Hailey disease (familial benign chronic pemphigus)
      3. Darier's disease (keratosis follicularis)
      4. Grover's disease (transient acantholytic dermatosis)
      5. Acantholytic actinic keratosis
   B. Viral disorders
      1. Herpes simplex
      2. Herpes zoster
      3. Varicella
   C. Spongiotic disorders
      1. Acute and subacute dermatitis

III. Subepidermal vesicles
   A. Degeneration of basal cells
      1. Lichen planus
      2. Lichen sclerosus et atrophicus
   B. Degeneration of basement membrane zone
      1. Dermatitis herpetiformis
      2. Bullous pemphigoid
      3. Erythema multiforme

II. Intraepidermal vesicles.

A. Acantholytic disorders

1. Pemphigus vulgaris

This is a truly primary acantholytic disorder characterized by dying acantholytic cells. The acantholysis occurs at the suprabasal level with no, or minimal, involvement of the more superficial stratum of the epithelium. Therefore, a suprabasal vesicle is formed which, early, contains many acantholytic cells (Figure 2). The lytic process involves the acrotrichium, an important diagnostic point. With aging of the blister, the roof is lost, inflammatory cells accumulate, and the regenerative process results in a multilayered base, therefore effacing our diagnostic criteria. Also, with aging, there is a gradual increase of a mixed dermal inflammatory infiltrate.

2. Hailey-Hailey disease (familial benign chronic pemphigus)

Hailey-Hailey disease is an acantholytic disorder of genetic dominance. Unlike pemphigus vulgaris, the acrotrichium is not involved. The process is suprabasal, extending throughout the full thickness of the epidermis. The result is a suprabasal cleft and the acantholysis above this level produces the well-known "falling or tumbling brick wall" effect (Figure 3). The protrusion of the dermal papillae into the vesicles suggests the formation of villi.

3. Darier's disease (keratosis follicularis)

This is an acantholytic disorder, autosomal dominant trait, at times with incomplete penetrance. As in Hailey-Hailey disease, there is a suprabasal clefting into which protrude dermal papillae forming villi (Figure 4). Characteristically, within the granular layer are corps ronds, large cells with a central dyskeratotic mass, surrounded by a clear halo and a rim of eosinophilic or basophilic cytoplasm. "Grains," present within the lacunae and horny layer, resemble large parakeratotic epithelial cells with an ellipse-like nucleus.

The acantholysis does not affect the upper layers of epithelium and, therefore, one does not see the tumbling brick wall effect as in Hailey-Hailey disease.

4. Grover's disease (transient acantholytic dermatosis)

This disorder may exhibit features of any of the foregoing acantholytic disorders (Figure 5) and cannot be excluded except on clinical information based on its historical transient nature.

5. Acantholytic actinic keratosis.

The clefts are in the same locations as in Darier's disease, but other changes are usually present to allow an easy differentiation.

II. Intraepidermal Vesicles

B. Viral disorders

The common vesicular diseases of viral origin are herpes simplex (herpesvirus hominis, types I and II), zoster and varicella (both caused by herpesvirus varicellae). Although the etiological agents differ and the clinical appearances are dissimilar, the histologic characteristics are about identical and the three must be discussed as one.

The vesicle is a product of two mechanisms which include balloon and reticular degeneration of the epithelial cells. The balloon cell is an enlarged squamous cell, containing multiple nuclei which are in "packets" and sometimes appear molded to each other, which may or may not appear to contain inclusions. The cells are round, have undergone acantholysis, and are free in a vesicle (Figure 6). In the more superficial strata of the epithelium, cells become edematous to the point of bursting, forming locules contained by the residual cell walls (reticular degeneration), therefore resulting in a multilocular vesicle. In a later stage, these residual walls disappear and the vesicle becomes unilocular.

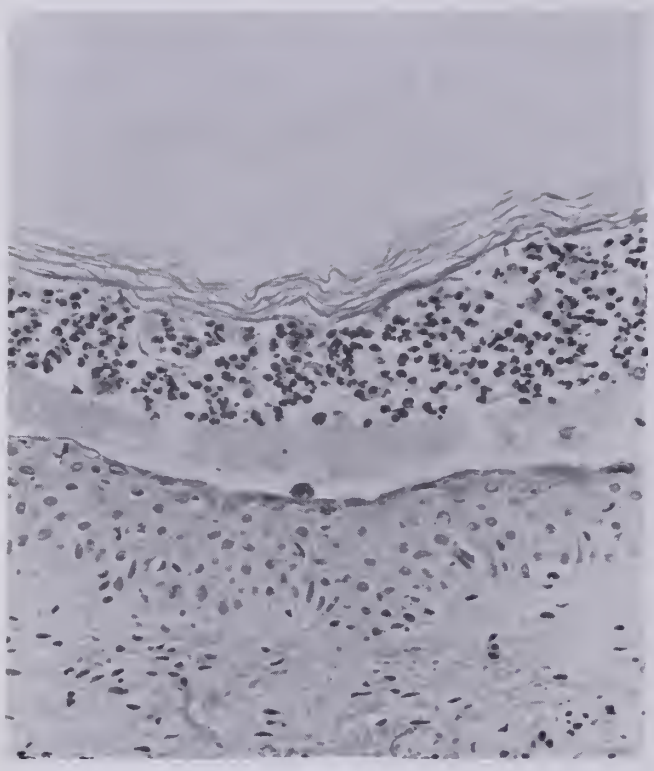


Fig. 1.—Subcorneal pustular dermatosis.
Numerous neutrophils lie just under the horny layer. The stratum malpighi is essentially normal.

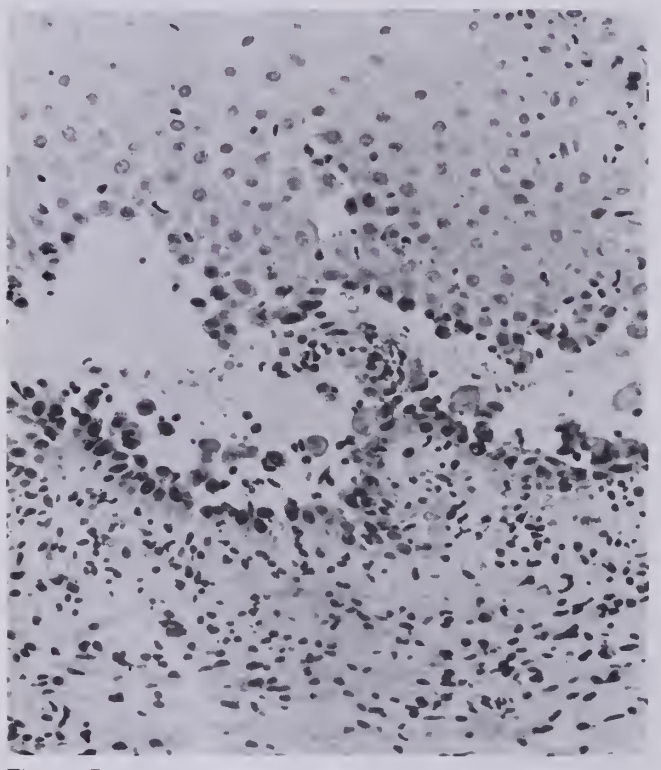


Fig. 2.—Pemphigus vulgaris.
This is a suprabasal vesicle containing acantholytic keratinocytes.

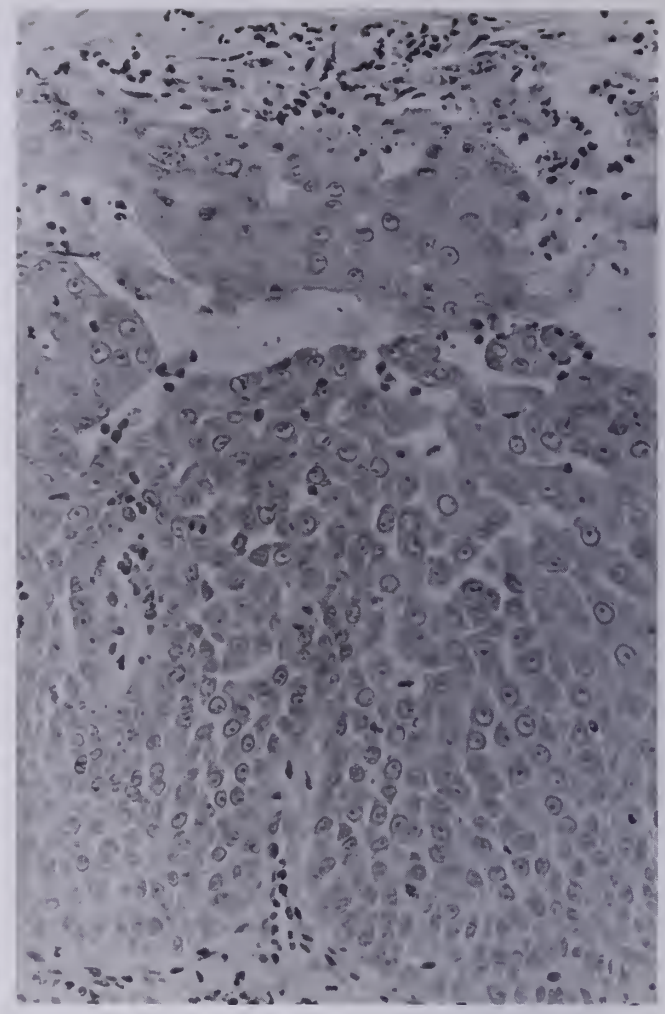


Fig. 3.—Hailey-Hailey.
Partial acantholysis with most of the keratinocytes retaining their intercellular bridges (dilapidated brick wall). Note a few mitoses, a common feature of Hailey-Hailey.

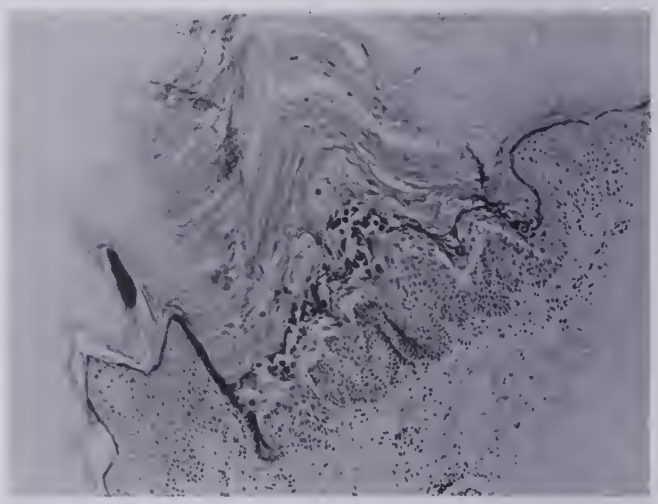


Fig. 4.—Darier's disease.
Proliferation of rete ridges, lacunae, corps ronds, and grains are the hallmark of Darier's disease.

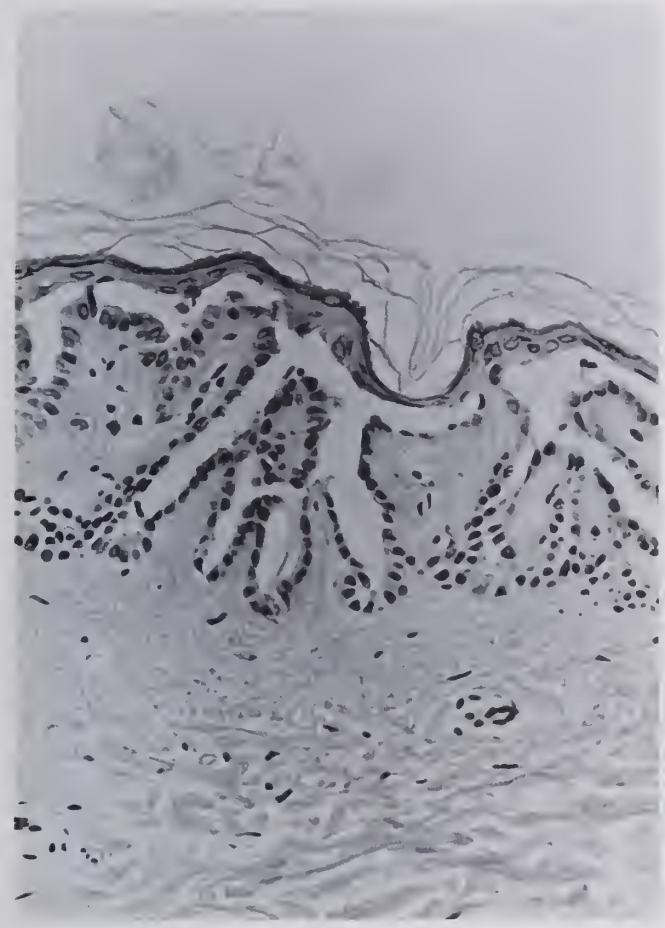


Fig. 5.—Transient acantholytic dermatosis.
The very well defined clefts of TAD are seen just above the basal layer. The underlying dermis is not affected.

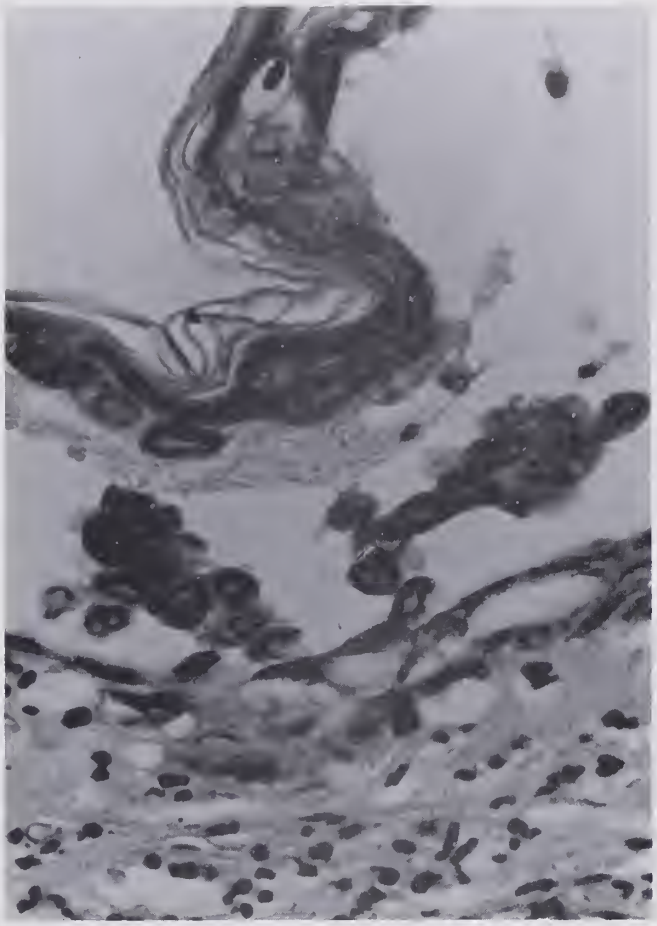


Fig. 6.—Herpes.
Large multinucleated balloon cells with eosinophilic intranuclear inclusions are seen in this vesicle.

A rapid diagnosis is possible if one finds the multinucleated balloon cells, using a Wright or a Giemsa stain of a smear prepared from fluid taken from an early blister. Within 48 hours, because of necrosis and purulent exudate, the cells may be difficult to identify. These vesicles are on an inflammatory base.

II. Intraepidermal vesicles.

C. Spongiotic disorders

The vesicles, such as one sees in an acute or subacute dermatitis, be it contact or whatever, are formed by the mechanism of reticular degeneration as described for viral vesicles. The vesicles contain a varying amount of polys and lymphocytes (Figure 7). Balloon cells, such as one sees with the viral diseases, are not present here.

III. Subepidermal vesicles.

A. Degeneration of basal cells

Destruction of the basal cells, so-called hydropic degeneration or cytolysis, results in vesicles or clefts which may occur in lichen planus (bullous lichen planus) and lichen sclerosus et atrophicus (Figure 8,9).

B. Degeneration of basement membrane zone

The basement membrane is seen by light microscopy using hematoxylin and eosin stain. It is seen as an eosinophilic band at the junction of the epidermis and the dermis. It is also seen, because of its mucopolysaccharide nature, as a PAS (periodic acid shift) positive band. The electron microscope sees this basement zone as a basal cell membrane separated by a space from the basal lamina, connected by anchoring fibrils. It is the basal lamina that one is actually visualizing with the PAS stain. Therefore, subepidermal vesicles may be further separated into two categories:

(1) those which cleft above the PAS membrane (begin within the space) with the visible membrane at the vesicle floor, and

(2) those with clefts below the basal lamina with the PAS positive membrane in the roof of the blister. Dermatitis herpetiformis and bullous pemphigoid are examples of the former, whereas erythema multiforme belongs to the latter group (membrane at roof).

(a) Supramembranous vesicles

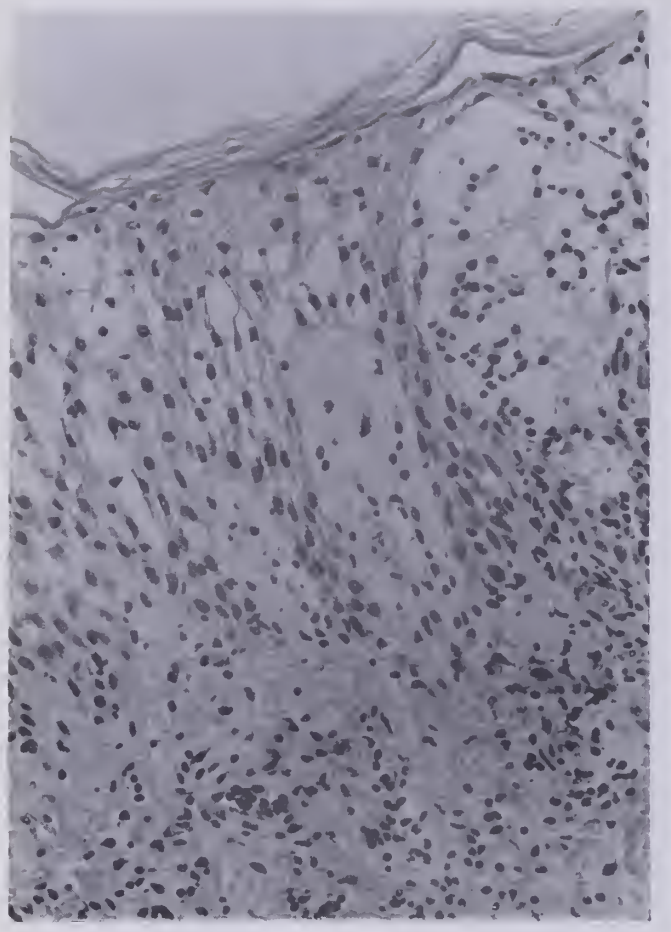


Fig. 7.—Acute dermatitis.
Spongiosis with reticular degeneration of the stratum malpighi and migration of leukocytes and lymphocytes into the epidermis.

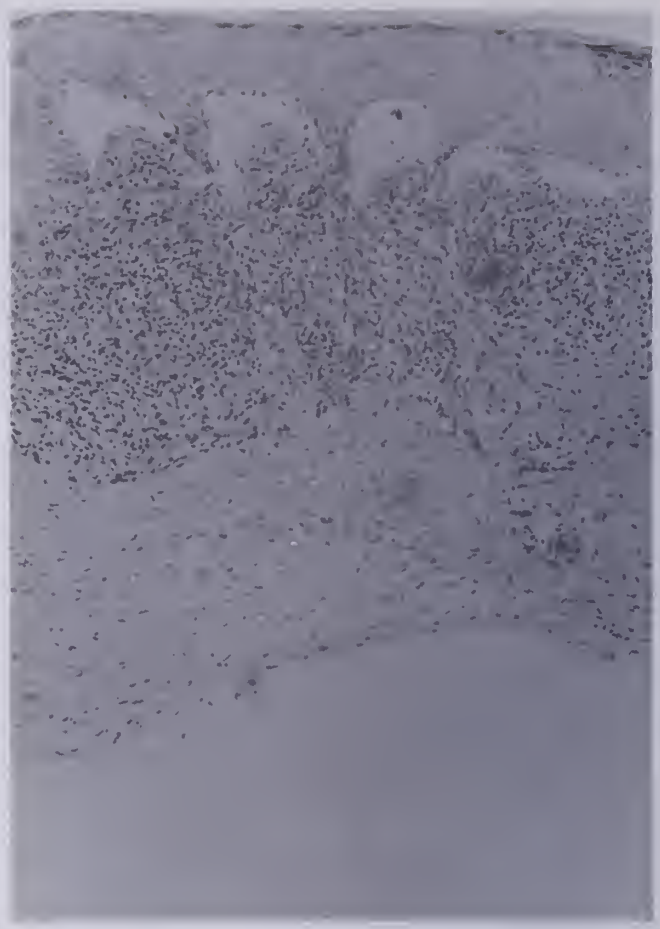


Fig. 8.—Lichen planus.
Multiloculated subepidermal bullae with "saw tooth" configuration of rete ridges, dense lymphocytic dermal infiltration hugging the epidermis, and hypergranulosis are seen in this form of lichen planus.

1. Dermatitis herpetiformis.

Again, the importance of biopsy of an early blister must be emphasized. The biopsy should include perivesicular skin to show the early diagnostic changes. In dermatitis herpetiformis, at the tips of the dermal papillae, there are collections of polys forming microabscesses (Figure 10) lifting off the epidermis and, at the same time, depressing the basement membrane. By occurring in sequentially adjacent papillae, a multilocular vesicle is formed. Contrary to popular belief, the early cellular component is the polymorphonuclear leukocyte (neutrophilic papillaritis) with the subsequent appearance of eosinophils. After 48 hours, the rete ridges are completely effaced and one no longer sees a multilocular vesicle but a unilocular vesicle (Figure 11) which resembles bullous pemphigoid. The same two cell types are present in the dermal papillae, some undergoing karyorrhexis, and there is also an inflammatory perivascular infiltrate.

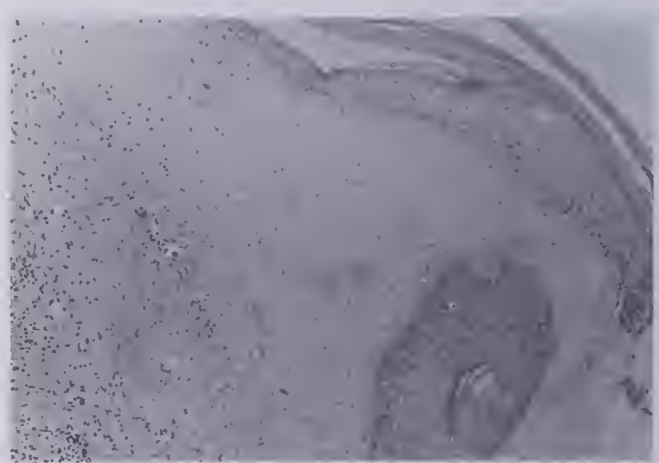


Fig. 9.—Lichen sclerosus et atrophicus.
Hyperkeratosis, atrophy, edematous upper dermis with underlying inflammatory band.

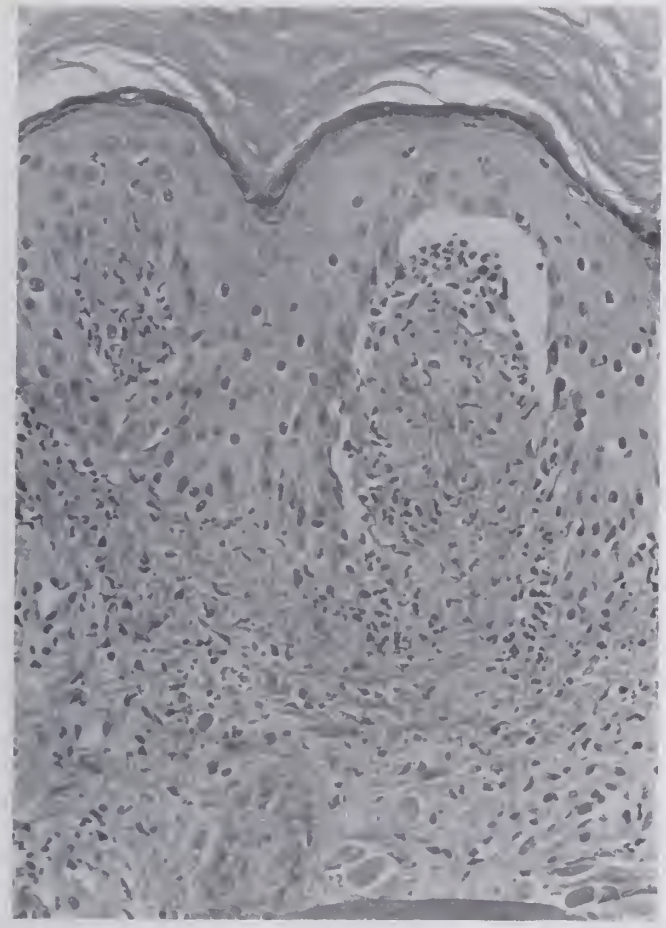


Fig. 10.—Dermatitis herpetiformis.
The very early lesion of neutrophilic papillaritis.

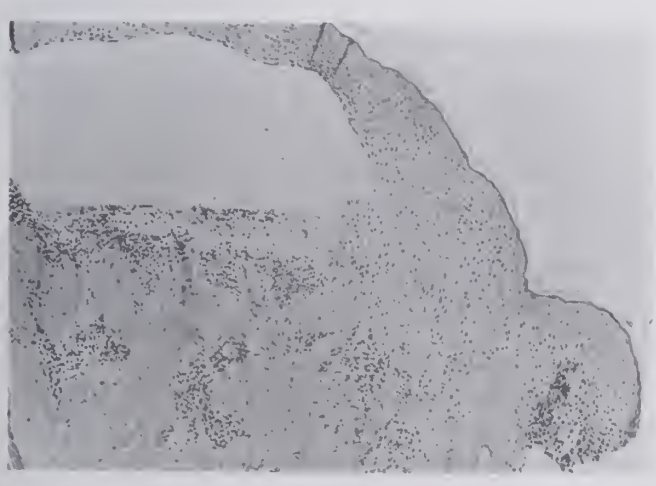


Fig. 11.—Dermatitis herpetiformis.
The fully developed subepidermal blister.

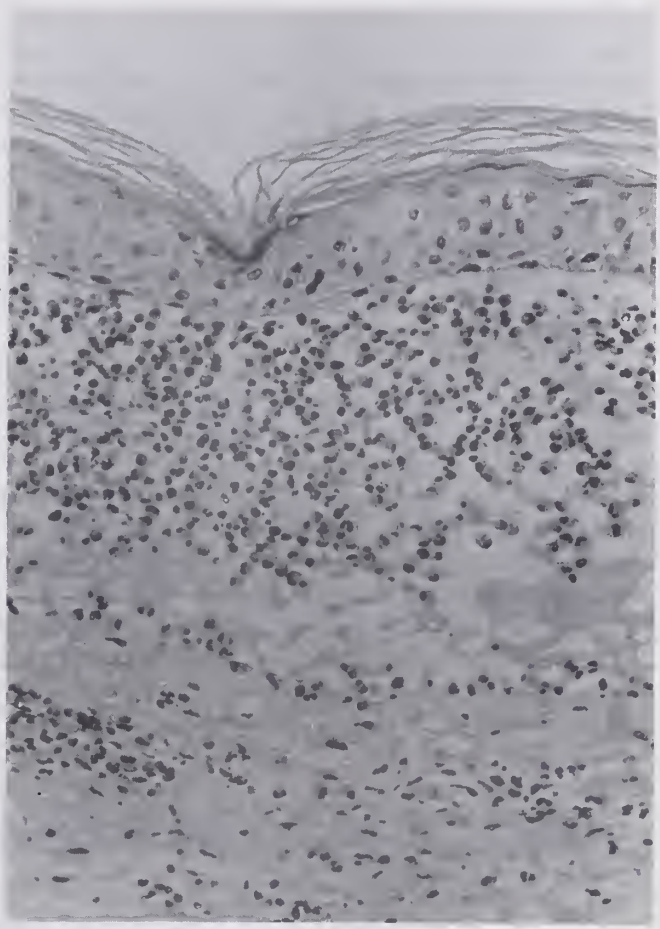


Fig. 12.—Bullous pemphigoid.
In this subepidermal vesicle, the predominant inflammatory cell is the eosinophil.

2. Bullous pemphigoid

As in dermatitis herpetiformis, the vesicle is formed by separation that begins within the intermembranous space. By light microscopy, one sees what can be described as "hydropic degeneration" of the epidermal-dermal interface, with formation of a unilocular tension blister. The normal undulations of the papillary dermis, known as "festooning," persist. The initial dominant cell within the blister is the eosinophil (Figure 12) and may simulate the microabscesses of dermatitis herpetiformis. Rapid regeneration from the acrotrichium and eccrine ducts "repaves" the floor of the blister and may mask its true subepidermal nature. The dermal base of the blister may vary from non-to severely inflamed.

(b) Submembranous vesicles

3. Erythema multiforme

The histopathology of erythema multiforme may vary tremendously, as does its clinical picture. Certain features, however, may be present which are characteris-

tic enough in combination to suggest the proper diagnosis. The presence of a dermal perivasculitis with an outpouring of edema fluid into the upper and papillary dermis, lifting off the epidermis, forms a blister. The basement membrane remains in the roof of the blister (as can be demonstrated by a PAS stain). Necrotic keratinocytes which appear eosinophilic may be seen singly, or in groups, or making up the entire roof. Again, it is to be remembered that because of necrosis, inflammation, and repair, the diagnostic features are lost after 48 hours.

We have attempted to outline a rather simplistic approach to the diagnosis of the more common vesiculobullous disorders. It has been assumed that the pathologist has not been afforded any clinical history or physical findings and that the biopsy has been presented merely as a "blister." Furthermore, the diagnostic armamentarium has been limited to light microscopy with routine hematoxylin and eosin stains and periodic acid shift stains. Even under these limited conditions, the familiarization with the location and mechanism of vesicle formation, and singular changes and responses, is of sufficient value to enable a pathologist to make some very valid conclusions. Of course, the proper approach necessitates the correct timing and site of biopsy and a thorough clinical orientation which, in itself, usually narrows the possible diagnoses to a few.

The information afforded by direct and indirect immunofluorescent studies can be extremely helpful in the more difficult cases and is readily available in standard texts and literature.

References are available from the authors upon request.

• Dr. Tamayo, Department of Pathology, Tampa General Hospital, Tampa 33606.

Estrogen and Progesterone Receptors In Human Breast Cancer

Daniel Seckinger, M.D.

Historical and General Overview

The most appropriate management of early and advanced breast cancer has been the subject of intensive study for the past several decades. The surgical procedure of choice for primary breast cancer is under intensive study and data as yet is not conclusive. The histologic grade of the cancer, the tumor size, axillary involvement and disease free interval, among others, are factors which have been investigated, hopefully to aid in selection of the appropriate therapy. An extensive study correlating the clinical aspects of breast cancer with the multiple pathologic correlates is published elsewhere.[1]

The role of chemotherapy and radiation therapy in management of advanced breast cancer is well established. The role of the estrogen receptor assay in directing management initially towards endocrine manipulation in lieu of chemotherapy or radiation therapy is now generally accepted.

Estrogen receptor levels appear to be an independent variable with a significantly greater predictive value regarding prognosis than any of the other variables.

Basic and applied clinical appreciation of the role of receptors has developed rapidly. Radioactive estrogen injected into experimental animals was first noted to localize in organs that excrete or respond to estrogen less than a generation ago.[2,3]

Jensen suggested that measurement of estrogen receptor levels in the human breast cancer cell might be an indication of hormone dependency. He postulated an in vitro assay of estrogen receptors using high specific activity tritiated estradiol.[4] More recently utilization of

progresterone receptor assay has provided additional insight into the biophysiology of receptor binding and transport within the target cell. Its combined utilization with the estrogen receptor assay provides yet additional predictive value of the therapeutic response.

Recognition and appreciation of the subpopulations of breast cancer has been enhanced by morphologic studies of cytochemical fluorescense[5] and recently autoradiographic demonstration of nuclear DNA synthesis.[6] Hopefully a better understanding of these subpopulations of breast cancer will enable more precise therapy, prognosis and diagnosis at the subcellular level.

Methodology

Our methodology for quantitation of receptors in breast cancer cells follows procedures described by McGuire.[7,8,9]

Estrogen receptor assay was an investigative procedure performed in relatively few large institutions until about five years ago. At that time the methodology of choice was analysis by the sucrose density gradient. In addition to precise quantitation of receptor protein the method had the advantage of demonstrating molecular forms of the receptor. The long and tedious procedure plus the cost of sophisticated equipment such as the ultracentrifuge placed limitations upon the number of samples that could be analyzed. With the advent of the dextran coated charcoal assay the measurement of receptors in breast cancer became more widely available in the clinical setting. Relatively large numbers of samples could be batched and processed simultaneously. Both methods provide for corrections for non-specific binding and each offers an evaluation of the type of estrogen binding, 4S and 8S peaks (by sucrose gradient) or dissociation constant (dextran coated charcoal). The two assays have been shown to give comparable results by several investigators.

A simplified or two point charcoal assay does not allow for calculation of the dissociation constant (K_d) and is not as well controlled as the two preferred methods.

At the time of operative consultation a representative aliquot of tumor is rapidly frozen until time for analysis. When it is pulverized and homogenized the resultant cytosol is prepared by centrifugation at precise speeds (150,000 x g). Aliquots of the cytosol are incubated with seven measured amounts of radioactive estradiol and with appropriate controls to exclude the non-specific binding component. After incubation dextran coated charcoal is used to separate free from receptor bound tritiated estradiol. The bound radioactivity is then determined for each sample. From these results binding capacity and dissociation constant (K_d) are calculated according to the method of Scatchard.[10] Estrogen and progesterone assays are performed in the receptor division of Interlab Associates, a collaborative reference laboratory in Miami, having experience with estrogen receptor assays on over 7500 breast tumors and combined estrogen and progesterone assays on over 3000 of the series. Graphic portrayal of results follow.

Role of the Pathologist

About four years ago it became obvious that estrogen receptor assays were necessary in management of breast cancer. A decision was made jointly by Chiefs of Surgery and Pathology at our institution to consider the assay a routine component of the surgical pathology examinations for breast cancer. The pathologist was designated as the responsible person to insure that the appropriate receptor assays were performed in all instances on representative tissue samples. After the operative consultation the surgeon and his staff are frequently involved with immediate preparations for the definitive operative procedure and a specific request for receptor assays may not be initiated. With the above precedent firmly established at Cedars of Lebanon Health Care Center over the past three years we have had the opportunity to evaluate a consecutive series of over 300 primary breast cancers or metastatic lesions for estrogen and progesterone receptor levels. We are indebted to the members of the Surgical Department for their judgment and cooperation. Our files contain



Dr. Seckinger

The Author

DANIEL SECKINGER, M.D.

Dr. Seckinger has served as Director of Laboratories at Cedars of Lebanon Health Care Center in Miami since 1961. A graduate of The George Washington University School of Medicine (1954), Dr. Seckinger interned in surgery and received two years of surgical residency training prior to four years of residency in pathology at The George Washington University Hospital and the Veterans Hospital in Miami. He is Associate Professor of Pathology at the University of Miami School of Medicine, where he and his associates take an active role in teaching medical students. Dr. Seckinger is Past President of the South Florida Society of Pathologists and currently serves as President of the Florida Society of Pathologists. He is a Delegate from Florida to the College of American Pathologists and a Fellow of the American Society of Clinical Pathologists. He has served three terms on the Executive Committee of the Dade County Medical Association and was Chairman of the Florida Medical Association's Committee on Drug Abuse. He also served as FMA's representative on the Governor's Drug Abuse Advisory Council. He presently is a member of the Board of Directors of the American Cancer Society, the Leukemia Society, the John Elliot Community Blood Center and Director of Cytopathology at the Papanicolaou Institute.

numerous case histories of therapeutic responses dependent on data derived from these studies.

We have been particularly interested in correlation of histologic types of breast cancer with receptor levels. Initial findings, based on our data over the past three years, are presented in detail elsewhere.[11]

There is surprisingly little correlation between pathologic features and estrogen receptor concentration. Two distinctive morphologic types of breast cancer may correlate with receptor levels. Our studies have indicated increased receptor values in lobular carcinoma of the breast. This parallels previously published observations.[12,13] We have observed decreased estrogen receptor values in six of seven medullary carcinomas studied to date.

The responsibilities of the surgeon, medical oncologist and radiation therapist to the patient with cancer of the breast are well defined. The pathologist has been relatively passive in some institutional settings, depending on requests from the clinician for specifc tissue studies. With our present awareness of the necessity of the receptor assay in management of the patient's disease, it is difficult to see why these studies are not performed routinely in all instances of breast cancer.

The pathologist's role as to specific responsibilities for receptor assay has been described in editorial form in the American Journal of Clinical Pathology.[14] It is essential that the aliquot of tissue identified for receptor assay is respresentative of the tumor. All too frequently fat, normal breast tissue and necrotic debris have been submitted for receptor assay. This sampling error is perhaps one of the factors contributing to certain disparities in large studies to date. We routinely perform a frozen section of tissue submitted for receptor assay as an internal control.

Tissue for assay must be quick frozen within twenty minutes of excision and maintained in a uniform frozen state until time for the assay. Several methods may be utilized for quick freezing. Liquid nitrogen (—196°C) is ideal but frequently unavailable. An acetone-dry ice bath (—78°C) or 1:1 slush of $CaCl_2$ with wet ice (—40°C) may also be used. The method most often utilized for the quick freeze of breast cancer tissue is carbon dioxide under pressure. Equipment is usually available as this is often the routine procedure employed for frozen section diagnosis. Tissue, however, should be stored in an ultracold freezer (—76°C) for any prolonged period of time prior to assay. Controlled studies on the adequacy of the various freezing methods have been limited. Diminished values are routinely observed with inadequate freezing techniques as with the numerous other artifactual factors introduced in sampling, handling or performance of the assay. Significantly diminished estrogen receptor values have been described by relatively slow freezing and maintenance in the cryostat cold chamber, especially those systems having a fluctuating defrost cycle. Any exposure to formalin or the various embedding media interfere with test methodology and also create artifactually reduced values.

The tissue sample submitted for assay ideally measures one cubic centimeter. The absolute minimum necessary for preparation of cytosol for the assay is 0.5 gm.

Methylene blue has been advocated in the surgical literature as an aid in localization of mammographically apparent but non-palpable breast lesions, thus facilitating excision. Our preliminary studies indicate that the incorporation of methylene blue in tissue submitted for assay is associated with decreased values, possibly by interference in the quenching phase of the assay or displacement of estradiol from receptors by the chemical dye.[15]

Receptor Biology and Mechanism of Estrogen Action

Steroids probably enter target cells passively and are then bound to cytoplasmic macromolecules which are specific receptor proteins. The cell has many receptors with specific affinity for the steroid hormones that may enter. Studies by sucrose gradient have characterized the receptor molecule as 4S or 8S fraction depending on tonicity of the buffer solution. When estrogen becomes bound to the receptor there is a transformation from 4S to 5S fraction by sedimentation gradients. It is not certain whether estrogen binding occurs initially in the cytoplasm or later in the nucleus. The estrogen receptor complex translocates to the cell nucleus where it interacts with one or more components of the chromatin complex. The resultant alteration in gene expression initiates the biologic responses we appreciate as "estrogen effect."

The cells of breast cancer contain these receptors. It is this receptor protein complex that is measured by one of the traditional receptor assays. If tumor cells maintain the integrity of the receptor pathway, they may be influenced by endocrine secretions and are considered estrogen receptor positive. Cells of these hormone dependent tumors reveal higher amounts of receptor protein. A breast tumor is considered "estrogen receptor positive" if it contains greater than 10 femtomoles/ng cytosol protein and "estrogen receptor negative" if it contains less than 3 femtomoles/ng cytosol protein. A "borderline" category is reserved for those lesions having between 3 femtomoles/ng cytosol protein and 10 femtomoles/ng cytosol protein. The borderline values are generally included with positives in large series (Table 1).[16] The exceedingly small percentage of tumors that are ER— and PgR+ would seem to enforce the proposed role

of progesterone receptor as an intermediate marker in cytoplasmic estrogen binding and translocation to the nucleus. A significant number of tumors with elevated progesterone receptors in the absence of increased estrogen receptor levels would present conceptual problems.

Table 1.
Total Cases and Distribution of Estrogen and Progesterone Receptor in Breast Cancer

	Total Cases	Percentages
ER+, PgR+	1432	52.1%
ER+, PgR—	661	24.1%
ER—, PgR+	48	1.7%
ER—,PgR—	605	22.0%
	2746	99.9%

Borderline values included with positives

Role of the Progesterone Receptor

Target tissues of the reproductive tract consistently reveal that progesterone effect is superimposed on tissue that has demonstrated a response to estrogen. Following the demonstration of the role of estrogen binding to the receptor and the relationship to management of metastatic lesions it was inevitable that progesterone receptor would be studied for its relationship to estrogen receptor and their combined effect on breast cancer.

The synthesis of progesterone receptor is dependent on estrogen induction in normal tissues and is a logical marker of this complex interrelationship of cytoplasmic binding of estrogen to the receptor complex and subsequent transport to the tumor cell nucleus.[17]

After several years of intense study there is a general awareness that the value of estrogen receptor measurements have extended beyond the initial role in breast cancer which was a guide to therapy of advanced disease. At present, values on the primary tumor serve as a major prognostic factor and correlate well with the disease free interval. The progesterone receptor is gaining in predictive value and is now accepted as a useful indicator of hormone dependence in metastatic breast cancer.

Antiestrogens

Recent interest in antiestrogens has been stimulated by an awareness of the relationship of estrogen and estrogen receptors to breast cancer. In past years endocrine therapy of advanced breast cancer consisted primarily of pharmacological doses of hormones or ablative surgery, usually major in scope and always on an empirical basis. With additional insight into mechanisms of estrogen binding the concept of an estrogen antagonist blocking at the receptor level becomes plausible, hopefully accomplishing similar result to ablative surgery but by non-invasive means.

Estrogen antagonists were earlier evaluated as contraceptive agents. They are weak estrogens, producing superficial cell proliferation of vaginal cells. Antiestrogens include synthetic steroids, synthetic non-steroidal compounds and natural steroids such as progestone, estriol and certain androgens. Their effects are somewhat paradoxical in that they produce short term effects comparable to estrogen but differ markedly with long term administration.[18] The number of doses, time sequence, concentration and relationship to systemic estradiol levels, all having a bearing on whether the end result is estrogenic or antiestrogenic. Most of the antiestrogens in current clinical use are synthetic non-steroidal derivatives of Triphenylethylene. They include Tamoxifen, Nafoxidine, MER 25 and Clomiphene.

The mechanism of antiestrogen tumor suppression is poorly understood. It is thought to be at the level of the estrogen receptor by many. The hypothalamic-pituitary axis and/or ovary may also be affected by antiestrogens and may be involved in tumor regression, either directly or indirectly.

Results of antiestrogen therapy essentially parallel ablative therapy. Most data are available on postmenopausal patients. Limited studies with premenopausal patients have shown a low response rate.[19]

For those interested in a thorough review of antiestrogen research and therapy a timely and comprehensive chapter may be found in the recent publication "Breast Cancer" edited by McGuire.[20]

Clinical Significance

Utilization of data recently generated is having a significant impact on developing trials of adjuvant therapy. Appreciation of progesterone receptor values as an additional marker in estrogen binding creates an additional parameter for initiation of early endocrine therapy.

Receptor values have a definite role in decision-making in advanced breast cancer. Patients can be conveniently divided into four groups (Table 2). Those

Table 2.
Management of Advanced Breast Cancer

Estrogen Receptor	Progesterone Receptor	Therapy
Negative	Negative	Chemotherapy
Negative	Positive	Not established as yet; rare
Positive	Negative	Antiestrogen trial with or without chemotherapy
Positive	Positive	Endocrine therapy

that are ER+ and PgR+ are very responsive to endocrine manipulation and over 80% should respond. About 30% of those patients that are ER+ and PgR— will respond to endocrine therapy. A trial with antiestrogens as a component of adjuvant therapy may be indicated. If estrogen and progesterone receptors are negative, there is little probability that endocrine therapy will be of value and the patient should receive combination chemotherapy.

There is also a strong probability that receptor data will aid in management of primary breast cancer (Table 3). Patients may be conveniently divided into four groups depending on axillary node status and presence or absence of estrogen receptors in the tumor. Patients with positive axillary lymph nodes and negative receptor values obviously have the worst prognosis and should receive intensive combination therapy.[21] Those patients with positive axillary lymph nodes and positive estrogen receptors might respond to endocrine therapy. In the absence of demonstrable metastases antiestrogen therapy is considered preferable to ablative surgery. The group with negative axillary lymph nodes and positive estrogen receptor values represents the best prognosis and should be observed without additional therapy. There are conflicting observations regarding management of the group with negative axillary lymph nodes and negative receptors. They are considered to be at greater risk for earlier recurrence. Some investigators have postulated a trial of non-alkylating cytotoxic agents for this group.

Table 3. Management of Primary Breast Cancer

Axillary Lymph Nodes	Estrogen Receptor	Therapy
Negative	Negative	? Chemotherapy
Negative	Positive	Clin. Observation
Positive	Negative	Chemotherapy
Positive	Positive	Antiestrogens and/or Chemotherapy

The above suggestions relating to management of advanced and especially early breast cancer are as yet far from established clinical dogma. Tabular representations are presented as simplistic portrayals in a rapidly evolving clinical area that incorporates much data recently generated.

Summary

In the past decade there has been widespread acceptance of the role of specific cytoplasmic receptor proteins in mediating steroid hormone action in endocrine responsive tissues. Our appreciation of estrogen and progesterone receptor activity has most direct clinical application in breast cancer. Clinical correlations between the degree of receptor positivity and therapy to be employed are well established in advanced breast cancer. Recent data indicate that receptor levels also have a major prognostic significance as an independent variable in primary breast cancer. The empirical approach to management of advanced breast cancer is no longer indicated. Patients whose breast tumors show elevated receptor levels are primary candidates for endocrine therapy of advanced disease and in approximately 60% of the cases remission of disease is to be anticipated. Clinical awareness of the role of receptors has created an intense interest in antiestrogen therapy in selected tumors and an earlier and more aggressive approach to combined chemotherapy in another group of tumors.

Estrogen receptor values are usually similar in primary and metastatic tumors. It is essential that receptor activities be determined in the primary tumor for subsequent choice of therapy as adequate amounts of tissue for assay are frequently not obtainable from metastases.

The determination of estrogen receptor levels is the most significant diagnostic study available in management of breast cancer today and is a necessary component of the pathologist's examination of a breast cancer.

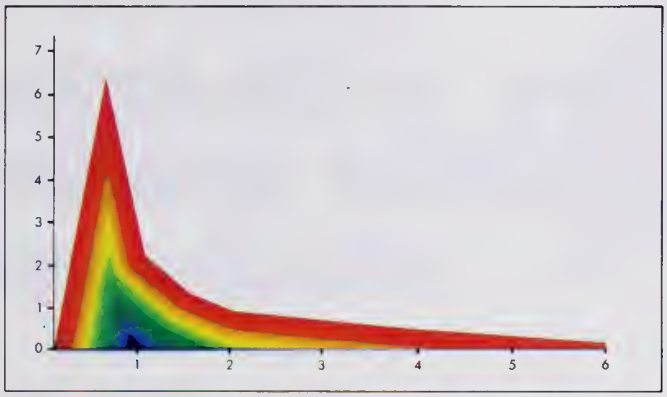
References are available from the author upon request.

Acknowledgements

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• Dr. Seckinger, Cedars of Lebanon Health Care Center, 1400 N. W. 12th Avenue, Miami 33136.

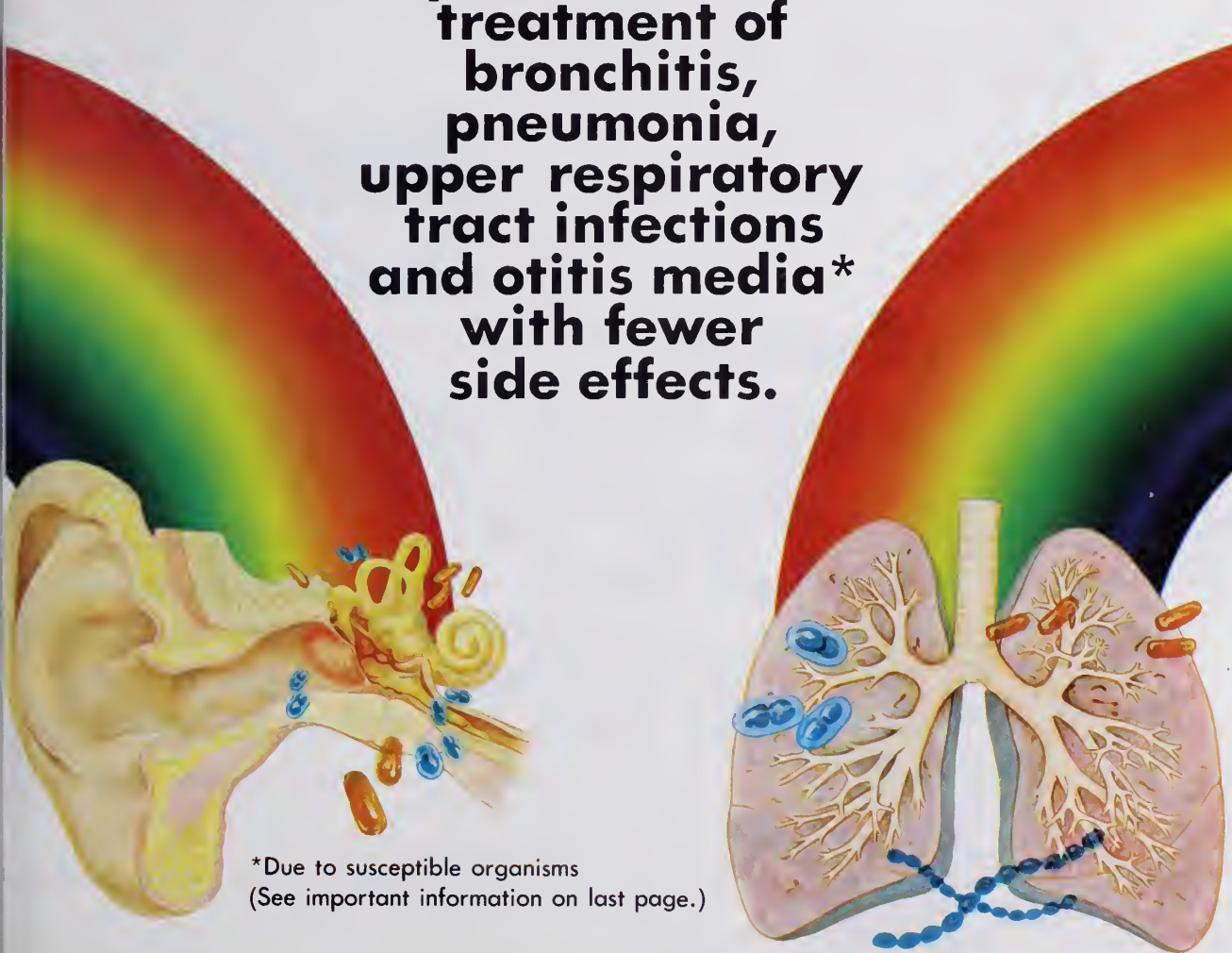
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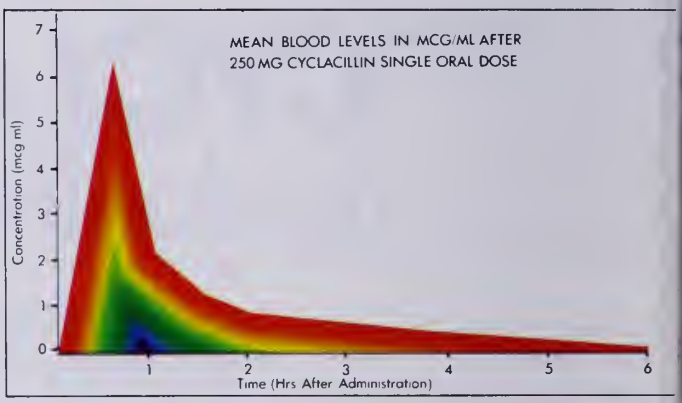
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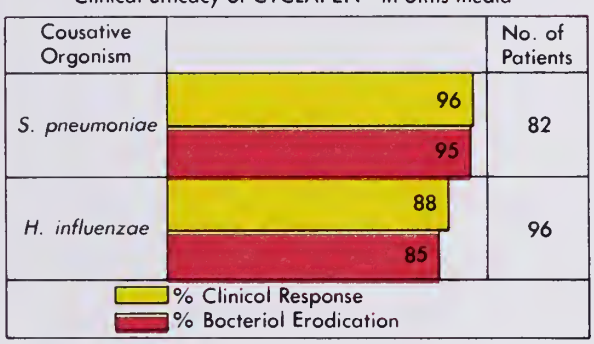


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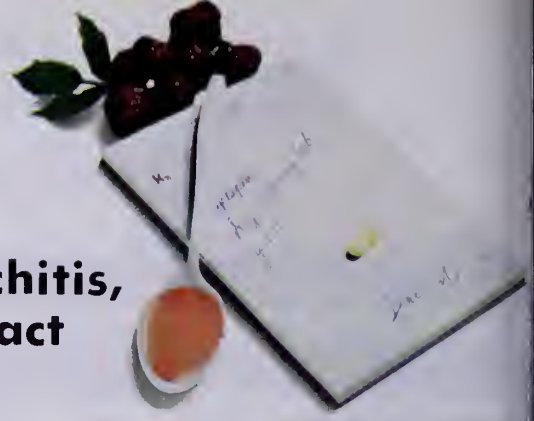
(cyclacillin) Tablets/ Suspension

yeth Laboratories
Philadelphia Pa 19101

e important information on next page)

New from Wyeth Laboratories

CYCLAPEN®
(cyclacillin) Tablets/ Suspension



more than just spectrum in bronchitis, pneumonia, upper respiratory tract infections and otitis media*

- Rapid, virtually complete absorption from GI tract
- Rapid onset of action—mean peak serum levels within 30 minutes
- Exceptionally high peak blood levels—3 times greater than ampicillin (clinical efficacy may not always correlate with blood levels)
- Rapidly excreted unchanged in the urine—1½ times faster than ampicillin
- Significantly fewer episodes of diarrhea and skin rash than reported with ampicillin in studies to date
- Excellent clinical response and outstanding bacterial eradication documented in double-blind studies involving 2,581 patients
- New CYCLAPEN® Suspension—great-tasting raspberry punch flavor

*Due to susceptible organisms.

How Supplied

CYCLAPEN® (cyclacillin) tablets:
250 mg scored tablets
500 mg scored tablets

CYCLAPEN® (cyclacillin) for oral suspension
125 mg per 5 ml:
100 ml and 200 ml bottles
250 mg per 5 ml:
100 ml and 200 ml bottles

Indications

Cyclapen® (cyclacillin) has less in vitro activity than other drugs in the ampicillin class of antibiotics and its use should be confined to the indications listed below

Cyclapen® is indicated for the treatment of the following infections

RESPIRATORY TRACT

Tonsillitis and pharyngitis caused by Group A beta-hemolytic streptococci

Bronchitis and pneumonia caused by *S. pneumoniae* (formerly *D. pneumoniae*)

Otitis Media caused by *S. pneumoniae* (formerly *D. pneumoniae*) and *H. influenzae*

Acute exacerbation of chronic bronchitis caused by *H. influenzae**

*Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzae*

SKIN AND SKIN STRUCTURES (integumentary) infections caused by Group A beta-hemolytic streptococci and staphylococci, non-penicillinase producers

URINARY TRACT INFECTIONS caused by *E. coli* and *P. mirabilis* (This drug should not be used in any infections caused by *E. coli* and *P. mirabilis* other than urinary tract infections.)

NOTE: Cultures and susceptibility tests should be performed initially and during treatment to monitor the effectiveness of therapy and the susceptibility of bacteria. Therapy may be instituted prior to the results of sensitivity testing.

Contraindications

The use of this drug is contraindicated in individuals with a history of an allergic reaction to penicillins.

Warnings

CYCLACILLIN SHOULD ONLY BE PRESCRIBED FOR THE INDICATIONS LISTED IN THIS INSERT.

CYCLACILLIN HAS LESS *IN VITRO* ACTIVITY THAN OTHER DRUGS OF THE AMPICILLIN CLASS ANTIBIOTICS. HOWEVER, CLINICAL TRIALS HAVE DEMONSTRATED THAT IT IS EFFICACIOUS FOR THE RECOMMENDED INDICATIONS.

SERIOUS AND OCCASIONAL FATAL HYPERSENSITIVITY (ANAPHYLACTOID) REACTIONS HAVE BEEN REPORTED IN PATIENTS RECEIVING PENICILLIN.

ALTHOUGH ANAPHYLAXIS IS MORE FREQUENT FOLLOWING PARENTERAL ADMINISTRATION, IT HAS OCCURRED IN PATIENTS ON ORAL PENICILLINS. THESE REACTIONS ARE MORE APT TO OCCUR IN INDIVIDUALS WITH A HISTORY OF SENSITIVITY TO MULTIPLE ALLERGENS. THERE ARE REPORTS OF PATIENTS WITH A HISTORY OF PENICILLIN HYPERSENSITIVITY REACTIONS WHO EXPERIENCED SEVERE HYPERSENSITIVITY REACTIONS WHEN TREATED WITH A CEPHALOSPORIN. BEFORE THERAPY WITH A PENICILLIN, CAREFUL INQUIRY SHOULD BE MADE ABOUT PREVIOUS HYPERSENSITIVITY REACTIONS TO PENICILLINS, CEPHALOSPORINS, AND OTHER ALLERGENS. IF AN ALLERGIC REACTION OCCURS, THE DRUG SHOULD BE DISCONTINUED AND APPROPRIATE THERAPY SHOULD BE INITIATED. SERIOUS ANAPHYLACTOID REACTIONS REQUIRE IMMEDIATE EMERGENCY TREATMENT WITH EPINEPHRINE. OXYGEN, INTRAVENOUS STEROIDS, AIRWAY MANAGEMENT, INCLUDING INTUBATION, SHOULD ALSO BE ADMINISTERED AS INDICATED.

Precautions

Prolonged use of antibiotics may promote the overgrowth of nonsusceptible organisms. If superinfection occurs during therapy, appropriate measures should be taken.

PREGNANCY: Pregnancy Category B. Reproduction studies have been performed in mice and rats at doses up to ten times the human dose and have revealed no evidence of impaired fertility or harm to the fetus due to cyclacillin. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

NURSING MOTHERS: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when cyclacillin is administered to a nursing woman.

Adverse Reactions

The oral administration of cyclacillin is generally well tolerated.

As with other penicillins, untoward reactions of the sensitivity phenomena are likely to occur, particularly in individuals who have previously demonstrated hypersensitivity to penicillins or in those with a history of allergy, asthma, fever, or urticaria.

The following adverse reactions have been reported with the use of cyclacillin: diarrhea (in approximately 1 out of 20 patients treated), nausea and vomiting (in approximately 1 in 50), and skin rash (in approximately 1 in 60). Isolated instances of headache, dizziness, abdominal pain, vaginitis, and urticaria have been reported. (See WARNINGS)

Other less frequent adverse reactions which may occur and that have been reported during therapy with other penicillins are: anemia, thrombocytopenia, thrombocytopenic purpura, leukopenia, neutropenia and eosinophilia. These reactions are usually reversible on discontinuation of therapy.

As with other semisynthetic penicillins, SGOT elevations have been reported.

Dosage and Administration

INFECTION*	ADULTS	CHILDREN
		Dosage should not exceed that in a dose higher than that for adults.
Respiratory Tract		
Tonsillitis & Pharyngitis**	25D mg q.i.d. in equally spaced doses	body weight <20 kg (44 lbs) 125 mg q.i.d. equally spaced doses body weight >20 kg (44 lbs) 250 mg q.i.d. equally spaced doses
Bronchitis and Pneumonia		
Mild or Moderate Infections	25D mg q.i.d. in equally spaced doses	5D mg/kg/day q.i.d. equally spaced doses
Chronic Infections	5DD mg q.i.d. in equally spaced doses	100 mg/kg/day q.i.d. equally spaced doses
Otitis Media	250 mg to 5DD mg q.i.d. in equally spaced doses depending on severity	5D to 1DD mg/kg/day equally spaced doses pending on severity
Skin & Skin Structures	250 mg to 500 mg q.i.d. in equally spaced doses depending on severity	5D to 1DD mg/kg/day equally spaced doses pending on severity
Urinary Tract	500 mg q.i.d. in equally spaced doses	1DD mg/kg/day in equally spaced doses

*As with antibiotic therapy generally, treatment should be continued for a minimum of 48 to 72 hours after the patient becomes asymptomatic or evidence of bacterial eradication has been obtained.

**In infections caused by Group A beta-hemolytic streptococci, a minimum of 1D days of treatment is recommended to guard against the risk of rheumatic fever or glomerulonephritis.

In the treatment of chronic urinary tract infection, frequent bacteriologic and clinical appraisal is necessary during therapy and may be required for several months afterwards.

Persistent infection may require treatment for several weeks.

Cyclacillin is not indicated in children under 2 months of age.

Patients with Renal Failure

Based on a dosage of 5DD mg q.i.d., the following adjustment in dosage interval is recommended:

Patients with a creatinine clearance of >5D ml/min need no dosage interval adjustment.

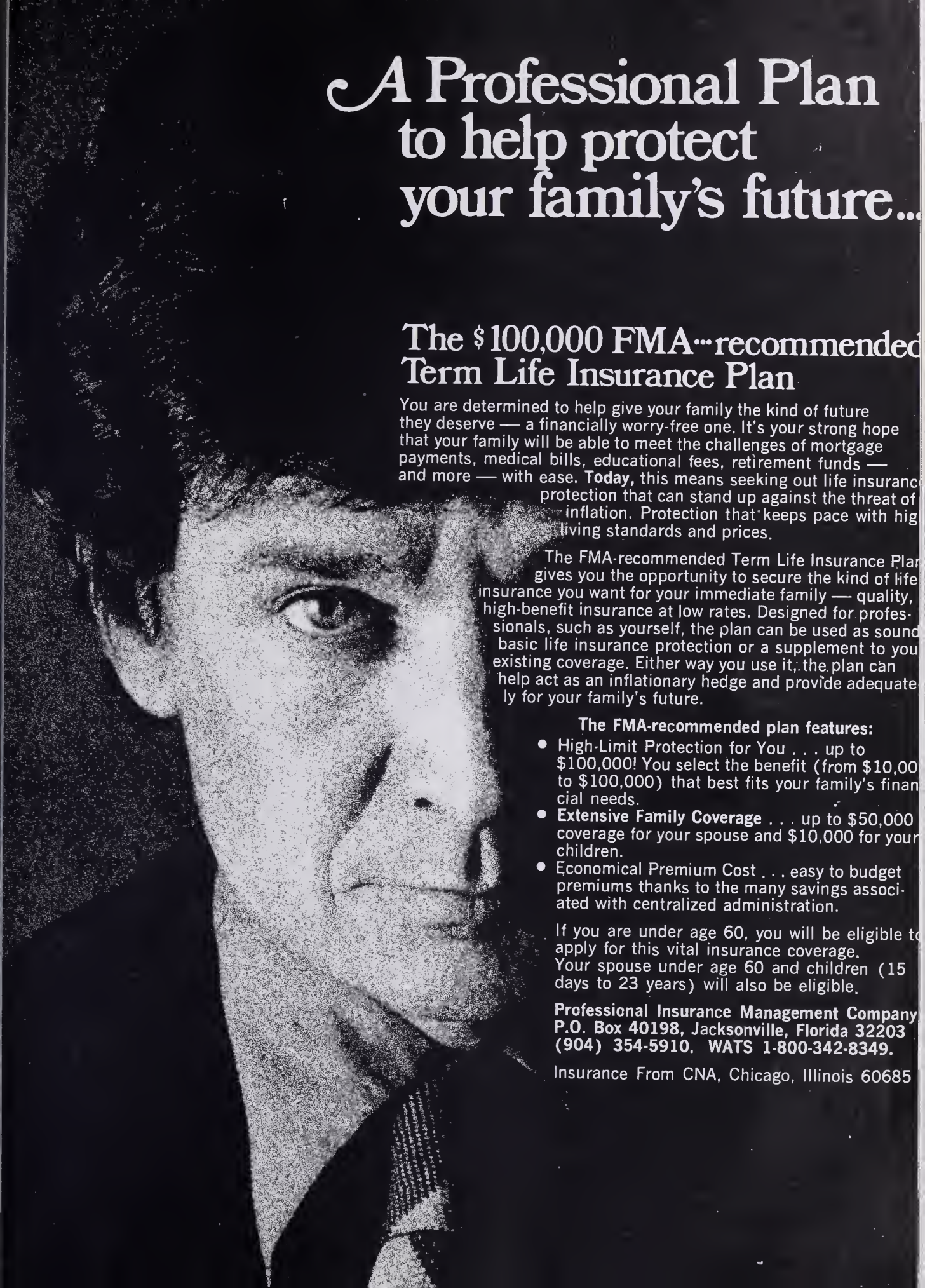
Patients with a creatinine clearance of 30-50 ml/min should receive full doses every 12 hours.

Patients with a creatinine clearance of between 15-3D ml/min should receive full doses every 18 hours.

Patients with a creatinine clearance of between 10-15 ml/min should receive full doses every 24 hours.

In patients with a creatinine clearance of ≤10 ml/min or serum creatinine values of > 10 mg%, serum cyclacillin levels are recommended to determine both subsequent dosage and frequency.

Wyeth Laboratories
Philadelphia, Pa 19101



A Professional Plan to help protect your family's future...

The $100,000 FMA-recommended Term Life Insurance Plan

You are determined to help give your family the kind of future they deserve — a financially worry-free one. It's your strong hope that your family will be able to meet the challenges of mortgage payments, medical bills, educational fees, retirement funds — and more — with ease. **Today,** this means seeking out life insurance protection that can stand up against the threat of inflation. Protection that keeps pace with high living standards and prices.

The FMA-recommended Term Life Insurance Plan gives you the opportunity to secure the kind of life insurance you want for your immediate family — quality, high-benefit insurance at low rates. Designed for professionals, such as yourself, the plan can be used as sound basic life insurance protection or a supplement to your existing coverage. Either way you use it, the plan can help act as an inflationary hedge and provide adequately for your family's future.

The FMA-recommended plan features:

- High-Limit Protection for You . . . up to $100,000! You select the benefit (from $10,000 to $100,000) that best fits your family's financial needs.
- **Extensive Family Coverage** . . . up to $50,000 coverage for your spouse and $10,000 for your children.
- Economical Premium Cost . . . easy to budget premiums thanks to the many savings associated with centralized administration.

If you are under age 60, you will be eligible to apply for this vital insurance coverage. Your spouse under age 60 and children (15 days to 23 years) will also be eligible.

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P.O. Box 40198, Jacksonville, Florida 32203
(904) 354-5910. WATS 1-800-342-8349.

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ORGANIZATION

State's Three Medical Schools Endorse Annual Meeting Scientific Program

Florida's three medical schools will once again join the Florida Medical Association in sponsoring the scientific program of this year's FMA Annual Meeting.

Agreement to co-sponsor the program was conveyed to the FMA Committee on Continuing Medical Education in letters from Deans E. M. Papper, M.D., of the University of Miami School of Medicine, Hollis G. Boren, M.D., of the University of South Florida College of Medicine, and William B. Deal, M.D., of the University of Florida College of Medicine.

Calvin W. Martin, M.D., of Arcadia, Vice Chairman of the Committee on CME and General Chairman for the Scientific Program, also said application had been made to the Florida Medical Foundation for its co-sponsorship and designation of Category I Credit for the meeting.

The Annual Meeting Scientific Program will be conducted Wednesday to Saturday, May 7-10, at the Diplomat Hotel in Hollywood, and will include the following sections, among others:

SATURDAY, MAY 10

SECTION ON PLASTIC AND RECONSTRUCTIVE SURGERY

(Co-sponsored by Florida Society of Plastic and Reconstructive Surgery)
8:00 a.m. to 10:00 a.m.
S. Anthony Wolfe, M.D., Miami
Program Chairman

"Coverage of an Unstable Radionecrotic Trochanteric Ulcer," Daniel Gruber, M.D., University of Miami School of Medicine, Miami.

"Application of Microsurgery," Felix Freshwater, M.D., University of Miami School of Medicine, Miami.

"Concealed Approaches for the Repair of Facial Injuries," Mutaz B. Habal, M.D., University of South Florida College of Medicine, Tampa.

"Research on Breast Implant Capsules in Dogs," Hollis Caffee, M.D., University of Florida College of Medicine, Gainesville.

SECTION ON PEDIATRIC CARDIOLOGY

(Co-sponsored by Florida Association of Pediatric Cardiologists)
8:00 a.m. to 10:30 a.m.
Ben Victorica, M.D., Gainesville
Program Chairman

"Cardiac Surgery in Infants"

"Open Heart Surgery: Techniques, Complications and Long-Term Effects," Gerard A. Kaiser, M.D., Department of Thoracic and Cardiovascular Surgery, University of Miami School of Medicine, Miami.

"Intra and Postoperative Monitoring and Management," James A. Alexander, M.D., Department of Thoracic and Cardiovascular Surgery, University of Florida College of Medicine, Gainesville.

"Ventricular Septal Defect: Pulmonary Bending vs. Early Closure — Surgical Results," Gerard A. Kaiser, M.D., Miami.

"Atrioventricular Canal: Surgical Approach and Results," James A. Alexander, M.D., Gainesville.

SECTION ON SURGERY

(Co-sponsored by Florida Chapter, American College of Surgeons, and Florida Association of General Surgeons)
9:30 a.m. to 11:00 a.m.
H. Quillian Jones Jr., M.D., Fort Myers
Program Chairman

"Trauma," Jerry Mark Shuck, M.D., Professor and Chairman, Department of Surgery, Case Western Reserve University School of Medicine, Cleveland, Ohio.

Liberty and Justice for All

INCLUDES RETARDED CITIZENS



UNIVERSITY OF MIAMI SCHOOL OF MEDICINE—DEPARTMENT OF MEDICI

FIFTEENTH ANNUAL POSTGRADUATE COURSE

"INTERNAL MEDICINE 1980"

March 9-14, 1980

AMERICANA HOTEL BAL HARBOUR, FLORIDA

THE OBJECT OF THIS COURSE, THE FIFTEENTH IN ITS SERIES, IS TO PROVIDE AN ANNUAL UPDATING OF THE MOST USEFUL RECENT ADVANCES IN THE DIAGNOSIS AND MANAGEMENT OF INTERNAL MEDICAL DISORDERS AS THEY ARE ENCOUNTERED BY PRIMARY CARE PHYSICIANS AND PRACTICING SPECIALISTS.

GUEST FACULTY

HAROLD O. CONN, M.D.
Professor of Medicine
Yale University
School of Medicine
Veterans Administration Hospital
West Haven CT

EDWARD D. FREIS, M.D.
Senior Medical Investigator
Veterans Administration Medical Center
Professor of Medicine
Georgetown University
School of Medicine
Washington, D.C.

LOUIS WEINSTEIN, Ph.D., M.D.
Visiting Professor of Medicine
Harvard Medical School, Physician
Peter Bent Brigham Hospital
Boston, MA

GERALD S. LEVEY, M.D.
Professor and Chairman
Department of Medicine
University of Pittsburgh
School of Medicine
Pittsburgh, PA 15261

SHAUN RUDDY, M.D.
Professor of Medicine and Microbiolog
Chairman, Division of Immunology and
Connective Tissue Disease
Virginia Medical College
Richmond, VA

HIGHLIGHTS

VIDEOTAPE SYMPOSIA OF TOPICS FOR BOARD REVIEW IN INTERNAL MEDICINE

Selected topics in Internal Medicine updated by the University of Miami faculty and primarily designed for physicians preparing for Board certification in Internal Medicine will be shown every evening.

MEET THE FACULTY SESSIONS "CRITICAL CARE IN INTERNAL MEDICINE"

Simultaneous group meetings will present topics of CRITICAL CARE IN INTERNAL MEDICINE. Special emphasis will be given to the most recent advances in the management of the critically ill patient.

STATE OF THE ART LECTURES*AUDIO VISUAL AIDS*SPOUSES ACTIVITIES*SCIENTIFIC EXHIBITS*HOTEL ATTRACTION

SUPERVISED CME ACTIVITIES: 35 Hours Credit

As an organization accredited for continuing medical education, the University of Miami School of Medicine certifies that this continuing medical education offering meets the criteria for 35 credit hours in Category 1 of the Physician's Recognition Award of the American Medical Association, provided it is used and completed as designed. Approval by the American Academy of Family Physicians for prescribed hours will be applied for.

SELF-INSTRUCTIONAL MATERIALS: 25 Hours Credit

As an organization accredited for continuing medical education, the University of Miami School of Medicine certifies that when these continuing medical education materials are used as directed, they meet the criteria for 25 hours of credit in Category 1 for the Physician's Recognition Award of the American Medical Association.

REGISTRATION: $350/Physicians $250/Physicians in Training*
*Letter from Chief of Service must accompany registration.

FOR REGISTRATION AND INFORMATION WRITE TO:

Jose S. Bocles, M.D.
Department of Medicine (R760)
University of Miami School of Medicine
P.O. Box 016760
Miami, Florida 33101
Phone: (305) 547-6063

NEW
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INFORMATION

clinical significance



of constipation

WILLIAM H. RORER, INC.
Fort Washington, PA 19034

Constipation acute or chronic

Constipation may be caused by conditions affecting the filling and emptying of the rectum.

Inadequate filling

Interference in propulsive contractions

Impairment of smooth muscle contractility

Obstruction of the lumen





Inadequate emptying

Interference in the stimulation of the defecation reflex

An additional complication

Self treatment—use and abuse of laxatives

Treatment of underlying disorders is critical... Relief of constipation is essential

Perdiem™...distinctive!

A unique blend of natural vegetable derivatives For comfortable and safe relief of constipation

Psyllium

- A noturol source of hydrophillic colloids
- Strengthens stimulus to defecote by increasing indigestible residue
- Helps produce soft, hydroted, well formed stool



Senna

- Produces mild peristaltic stimulation
- Helps propel bulk through colon



A unique granular formulation

- No mixing or chewing
- Granules ore ploced in mouth ond swollowed with full glass of beveroge
- Helps breok cothartic hobituotion
- Helps estoblish normal defecatory reflexes ond regular bowel rhythm

John Moerz, M.D.
Medicol Director
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Deor Dr. Moerz:

Yes, I would like to receive o supply of Perdiem™ storter somples for my potients.

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SJ-312

New Perdiem™

Prescribing Information

ACTIONS: Perdiem™, with its gentle action, does not produce disagreeable side effects. The vegetable mucilages of Perdiem™ soften the stool and provide pain-free evacuation of the bowel. Perdiem™ is effective as an aid to elimination for the hemorrhoid or fissure patient prior to and following surgery.

COMPOSITION: Natural vegetable derivatives: A unique blend of psyllium and senna (Plantago Hydrocolloid with Cassia Pod Concentrate).

INDICATION: For relief of constipation.

PATIENT WARNING: Should not be used in the presence of undiagnosed abdominal pain. Frequent or prolonged use without the direction of a physician is not recommended. Such use may lead to laxative dependence.

DIRECTIONS FOR USE—ADULTS: Before breakfast and after the evening meal, one to two rounded teaspoonfuls of Perdiem™ granules should be placed in the mouth and swallowed with a full glass of warm or cold beverage. Perdiem™ granules should not be chewed. After Perdiem™ takes effect (usually after 24 hours, but possibly not before 36-48 hours): reduce the morning and evening doses to one rounded teaspoonful. Subsequent doses should be adjusted after adequate laxation is obtained.

IN OBSTINATE CASES: Perdiem™ may be taken more frequently, up to two rounded teaspoonfuls every six hours.

FOR PATIENTS HABITUATED TO STRONG PURGATIVES: Two rounded teaspoonfuls of Perdiem™ in the morning and evening may be required along with half the usual dose of the purgative being used. The purgative should be discontinued as soon as possible and the dosage of Perdiem™ granules reduced when and if bowel tone shows lessened laxative dependence.

FOR COLOSTOMY PATIENTS: To ensure formed stools, give one to two rounded teaspoonfuls of Perdiem™ in the evening with warm liquid.

DURING PREGNANCY: Give one to two rounded teaspoonfuls each evening.

FOR CLINICAL REGULATION: For patients confined to bed, for those of inactive habits, and in the presence of cardiovascular disease where straining must be avoided, one rounded teaspoonful of Perdiem™ taken once or twice daily will provide regular bowel habits. Take with a full glass of water or beverage.

FOR CHILDREN: From age 7—11 years, give one rounded teaspoonful one to two times daily. From age 12 and older, give adult dosage.

NOTE: It is extremely important that Perdiem™ should be taken with a plentiful supply of liquid.

HOW SUPPLIED: Granules; 100 gram (3.5 oz.) and 250 gram (8.8 oz.) canisters.



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FMA AUXILIARY

Auxiliary District Workshops

March is Spring Workshop month for the Florida Medical Association Auxiliary. Visiting each of the six Auxiliary districts will be President-Elect, Mrs. Fred P. Swing, and First Vice President, Mrs. Frank C. Coleman. Each district vice president will arrange the workshop in her district and take a vital part in the program.

Thrust of the workshops is toward orientation and reactivation for current and incoming Auxiliary officers and committee chairmen. Leadership training will be an important part of the program and each workshop will be tailored for the individual district. Considerable time will be spent in discussing problems and interests peculiar to the area. Every participant is encouraged to be vocal in the sessions — asking questions, sharing new ideas, and making the Auxiliary relevant to the times.

Programs and projects of the Auxiliary will be explained and discussed. All auxilians are encouraged to "Get Into the Act" for 1980-81, a very important year for medicine.

Representatives from district FMA offices will discuss legislation and tell us how the Auxiliary can effectively contribute to programs and policies fostered by the FMA. This is one of the most important priorities of your Auxiliary.

Workshops are designed to help each member recognize her own potentials and capabilities, and to encourage leaders to appreciate the abilities and value of others. The sessions will be successful only in so far as they help to develop effective leadership for the Auxiliary.

Workshop Schedule

Southwest, March 3, 1980 — Port Charlotte
West Central, March 4, 1980 — Tampa
Northwest, March 5, 1980 — Navarre Beach
Northeast, March 11, 1980 — Ocala
East Central, March 12, 1980 — Indialantic
South, March 13, 1980 — Fort Lauderdale

Anne Swing (Mrs. Fred P.)
President-Elect
FMA Auxiliary
Charlotte Harbor

One of the best ways to win respect as a leader is to keep your promises.

A SPECIAL PROGRAM

presented by **NORTH RIDGE MEDICAL CENTER**

sponsored by **NORTH RIDGE GENERAL HOSPITAL**
LEO GOODWIN INSTITUTE FOR CANCER RESEARCH

Biologic Control of Human Cancer

February 16 and 17, 1980

AUDITORIUM
NORTH RIDGE GENERAL HOSPITAL
5757 North Dixie Highway
Fort Lauderdale, Florida

REGISTRATION FEE: **$35.00**
RESIDENTS, INTERNS, STUDENTS: **$20.00**
LUNCHEON SATURDAY

9 C.M.E. Credit Hours

General Chairman: WILLIAM O. RUSSELL, M.D.

Saturday, 8:30 a.m.
MOLECULAR MEDIATORS OF CELL GROWTH & HUMAN IMMUNE RESPONSE

Joseph G. Sinkovics, M.D., Chairman
Director of Clinical Research
Leo Goodwin Institute for Cancer Research,
Professor of Virology and Epidemiology
Baylor College of Medicine, Houston, Texas

Jules E. Harris, M.D.
Director of Medical Oncology
Rush-Presbyterian-St. Luke's
Medical Center
Chicago, Illinois

Bismarck B. Lozzio, M.D.
Chief
Laboratory of Experimental Hematology
& Oncology, University of Tennessee
Memorial Research Center
Knoxville, Tennessee

Grace Faillace Memorial Lecture: . . . . . Joseph G. Sinkovics, M.D.
Rediscovery of Interferon as an Antineoplastic Agent

Saturday, 10:45 a.m.
TUMOR THERAPY: Potentiation and Synergism

Joel Warren, Ph.D., Chairman
Director, Leo Goodwin Institute for
Cancer Research
Ft. Lauderdale, Florida

Claire Ann Thuning, M.S.
Research Associate
Leo Goodwin Institute for Cancer Research
Ft. Lauderdale, Florida

Daniel von Hoff, M.D.
Assistant Professor of Medicine
University of Texas Health Science Center
San Antonio, Texas

Saturday, 2:00 p.m.
TUMOR DIFFERENTIATION: Conversion of Malignant Cells Toward Normal Cells

William O. Russell, M.D., Chairman
Director of Pathology
North Ridge General Hospital
Leo Goodwin Institute for Cancer Research
Clinical Professor of Pathology
University of Miami School of Medicine

Phillip Stansly, Ph.D.
Associate Chief
Biological Carcinogenesis Branch
Division of Cancer Cause and Prevention
National Cancer Institute,
Bethesda, Maryland

G. Barry Pierce, M.D.
Professor and Chairman
Department of Pathology
University of Colorado Medical Center
Denver, Colorado

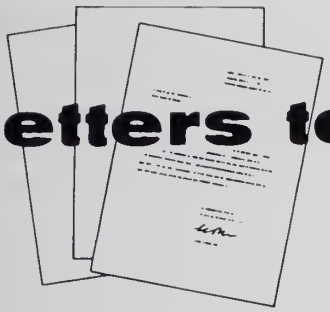
Sunday, 9:00 a.m.
RADIOBIOLOGY AND RADIOTHERAPY OF CANCER

Wallace D. Buchanan, M.D., Chairman
Radiotherapist
Broward General Medical Center
Ft. Lauderdale, Florida

Antolin Raventos, M.D.
Professor of Therapeutic Radiology
University of California (Davis) Medical Center
Sacramento, California

Registration is Limited

FOR FURTHER INFORMATION CONTACT Ms. Barbara Chandler, North Ridge General Hospital, 5757 North Dixie Highway, Fort Lauderdale, FL (305) 776-6000 Ext. 5100



Letters to the Editors

PSRO

Dr. H. S. Norris
No. 9, Doctors Bldg.
St. Augustine

Dear Dr. Norris: In 1972, without so much as a hearing in the House of Representatives, Professional Standards Review Organizations (PSROs) were created by law. Ironically, this is one program that could have used plenty of debate. Maybe some of its flaws could have been discovered before it went into effect.

Last week I reopened the PSRO debate by introducing an amendment to eliminate this costly and ineffective federal program. Recent studies by the Congressional Budget Office and the General Accounting Office backed up my contention that PSROs are counterproductive. The CBO report concluded that PSROs were spending $100 million in administration expenses for every $70 million they saved in Medicare costs. The GAO audit found that savings reported by nine PSROs were unsubstantiated.

This faulty federal program also tampers with a physician's discretion to prescribe individualized treatment. PSRO norms and guidelines, which must be approved by the federal government, amount to cookbook medicine. Codified standards for medical treatment not only retard innovation and improvements in health care, they also interfere with the physician's discretion to handle each case uniquely and personally. In short, the quality of care is inhibited, not improved, by federal regulators.

Finally, I am concerned that PSRO review violates the deeply confidential relationship between doctor and patient. Medical records cannot be openly scrutinized without endangering many fundamental personal rights.

My amendment to eliminate the program and return to the far more successful pre-1972 concept of utilization review extracted from the Health Subcommittee a commitment for extensive hearings on PSROs. After seven years the House will finally hold hearings on a program that should have been examined before it ever began to waste money, jeopardize health care quality, and abridge privacy. You may want to inform Chairman Charles Rangel, Health Subcommittee, A412 House Office Building Annex 1, Washington, D.C. 20515, of your views on this topic.

Congressman Philip M. Crane, M.C.
12th District, Illinois

THE SICK DOCTOR

Mr. Gene Scott
Executive Vice President, DCMA
Miami

Dear Mr. Scott: This is in reply to your letter of October 9, 1979 concerning the plans of the DCMA to set up a committee to assist the Sick Doctor.

You state that confidentiality is the basis on which you are hoping that more physicians would speak out about either their own problem or that of a colleague. You ask the question, when the Committee for the Well Being of Physicians is notified of a physician with a need for assistance, would the members of the Committee, either individually or collectively, be in violation of the Medical Practice Act, and therefore subject to disciplinary action by the Board, if they fail to inform the Board of Medical Examiners of the physician with the problem.

I cannot answer that question with either a yes or a no. My answer is this. Members of your Society should report each physician to the Committee on an individual basis and in confidence. The Committee should then act in confidence and make every effort to make the physician be aware of his problem, recognize his problem and take whatever avenues are available for dealing successfully with the problem. The Committee should insist that the physician cooperate completely or if not, then be subject to being reported to this Board.

If during the course of the Committee's dealing with

the physician, if the Committee feels that the physician is not a danger to the public and his patients and can practice with reasonable degree of skill and safety during rehabilitation, that is fine. If the Committee feels that the physician is and has been a danger to patients and to continue practice would be harmful to patients and that he has or is continuing to do harm to patients, then the Committee should make every effort to persuade the physician to stop practice until he or she is determined to be able to practice again with reasonable skill and safety to patients.

If the physician refuses to cooperate, stops treatment prematurely and in the opinion of the Committee is obviously a danger to the public and unable to practice with reasonable degree of skill and safety, then that physician should be reported to this Board.

I personally believe that as long as the Committee acts in good faith, with the danger to the public uppermost in mind, then this Board would not feel that the Committee or any of your members are violating the Medical Practice Act.

You wanted an answer quickly and I have consulted with Board legal counsel on this. I will also bring this up at our next Board meeting, but that may not be until early December.

I certainly hope that the DCMA will go on with plans to establish this Committee because such cooperation and efforts are absolutely essential in aiding the Board in dealing with the Sick Doctor. Ideally, you should be able to handle most of them and they will not even reach the Board.

I hope that this advice is helpful to you.

Sincerely yours,
George S. Palmer, M.D.
Executive Director
State of Florida
Board of Medical Examiners

MEDICINE UNDER ATTACK

To the Editor: Medicine and all of its branches are under attack, not only from bureaucrats, but also from para-medical and non-medical technicians who are trying to lower the standards of licensure so they may practice medicine even though they have not achieved the proper qualifications.

Ophthalmology, at present, seems to offer the most opportune target, but it will serve only as a precedent for the invasion of the practice of other branches of medicine by para-medical and non-medical groups.

The strategy by which non-medical groups hope to obtain medical status was clearly revealed when, in 1978, optometry launched a multi-million dollar nationwide advertising campaign. Those ads told an unsuspecting public that, "An examination by an optometrist is also a good place to begin guarding your family's total health care." They concluded this effort to bypass the general medical practitioner, the internist, and the pediatrician as well as the ophthalmologist by proclaiming, "Your Family Doctor of Optometry. The person to see. And keep seeing."

Optometrists have succeeded in obtaining by legislative fiat the right to use so-called diagnostic drugs in 21 states and therapeutic as well as diagnostic drugs in two states. Recently legislation was proposed in Arizona which would have permitted these same untrained non-medical practitioners to perform surgery on the eye and its adnexa.

The decline of Ophthalmic standards and the demise of ophthalmology as a recognized medical specialty would establish a precedent fraught with grave danger for all of medicine. It would provide both the legal sanctification and popular momentum that has so long been awaited by audiologists, nurse practitioners, psychologists and a host of other allied practitioners and non-medical technicians who seek to obtain by decree what they have failed to obtain by degree. This is emphasized by Iowa chiropractors in their suit against the AMA as they charge that the AMA and the rest of organized medicine have excluded chiropractors and prevented them from practicing their trade freely by controlling public access to them and other emerging health care practitioners such as nurses, physicial therapists and physician assistants.

Ophthalmology is taking its case to the people, in the interest of protecting the public health. An advertisement which appeared in several national magazines distributed throughout Michigan was sponsored by Michigan ophthalmologists. The ophthalmologists of this state are prepared to do as much and invite their professional colleagues to join them in a united effort to inform the public of these dangers to their health.

Nicholas H. Kalvin, M.D.
Naples, Florida

Kenneth R. Safko, M.D.
St. Petersburg, Florida

MEDICAID PROVIDERS

Robert B. Williams
Deputy Assistant Secretary for Medicaid
Department of HRS
Tallahassee

Dear Mr. Williams: Enclosed is a letter from SDC which my wife, Medicaid Provider #54364-1, received, listing adjustment invoices which could not be processed, and asking that she search out the invoices, correct the errors, and resubmit. Unfortunately, all but the first list recipient name as unknown, and identify the recipient only by number.

Not too long ago one of my office nurses became concerned about my extreme unhappiness over whatever was the Medicaid "problem du jour." Being a minister's wife, she resorted to her Bible. On the following day she proudly greeted me with the obvious explanation for the seemingly endless list of Medicaid problems. She directed me to chapter 13 of Revelation, which, by her interpretation, points out that God calls his people by name, while Satan calls his followers by number. Clearly Medicaid is in Satan's camp.

Sincerely yours,
Medicaid Provider #53704-7

Louis B. St. Petery Jr., M.D.
Tallahassee

Dear Louis (formerly known as Medicaid Provider #53704-7): Although Medicaid may once have been in Satan's camp, I am happy to inform you that after a great deal of soul searching we have "seen the light" and consider ourselves among God's chosen people." I noticed that in your November 5, 1979, correspondence you referred to yourself as Medicaid Provider #53704-7. I trust that that was only a momentary case of backsliding and that you are now back among the "chosen people."

Louis, I am sure that working together we can successfully convert most, if not all, of those poor souls still in Satan's camp. As a start, I have referred the information regarding adjustment invoices which you included in your November 5 letter to George Skinner of SDC to be researched. He will be in touch with you directly to resolve any outstanding problems. I look forward to our joint efforts to improve Medicaid systems to the point that these types of problems will be rare.

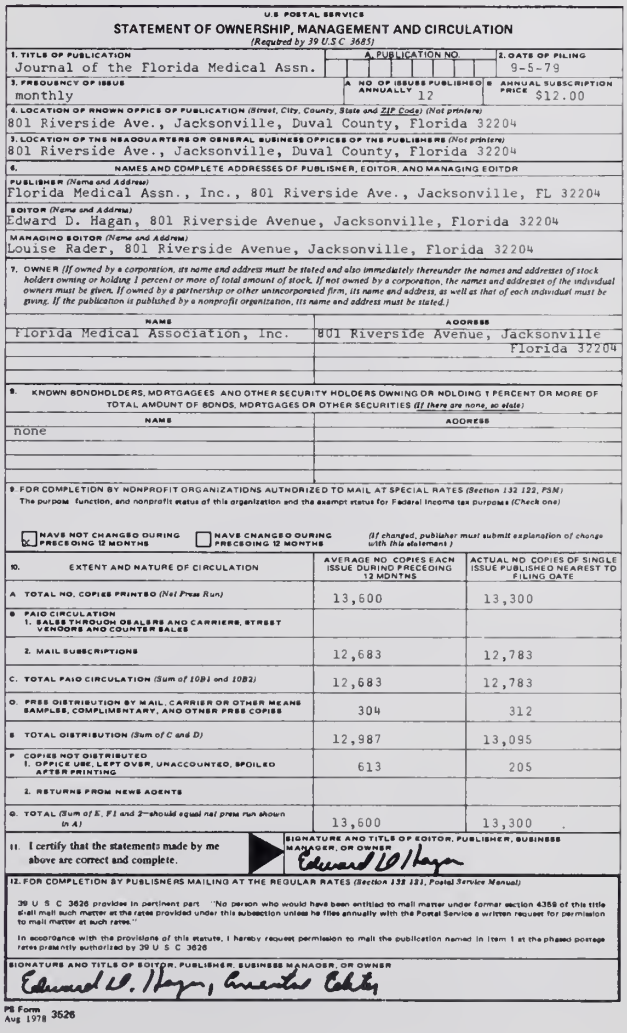
Sincerely,
Robert B. Williams
(formerly known as 263-80-7329)

FDA PUBLICATIONS AVAILABLE

To the Editor: FDA has recently issued two publications that provide useful background information about how the Agency operates. One is a compendium in non-legal language of the laws and regulations enforced by FDA and the other is the Agency's annual report for 1978. While both booklets treat information that is continually changing, they give a fairly full and broad picture of the various authorities under which the FDA carries out its responsibilities and the status of its programs.

I am pleased to provide copies for your use.

Sincerely yours,
Kenneth Flieger
Acting Deputy Associate Commissioner for Health Affairs (Education and Professional Training)
Food and Drug Administration
Rockville, MD.



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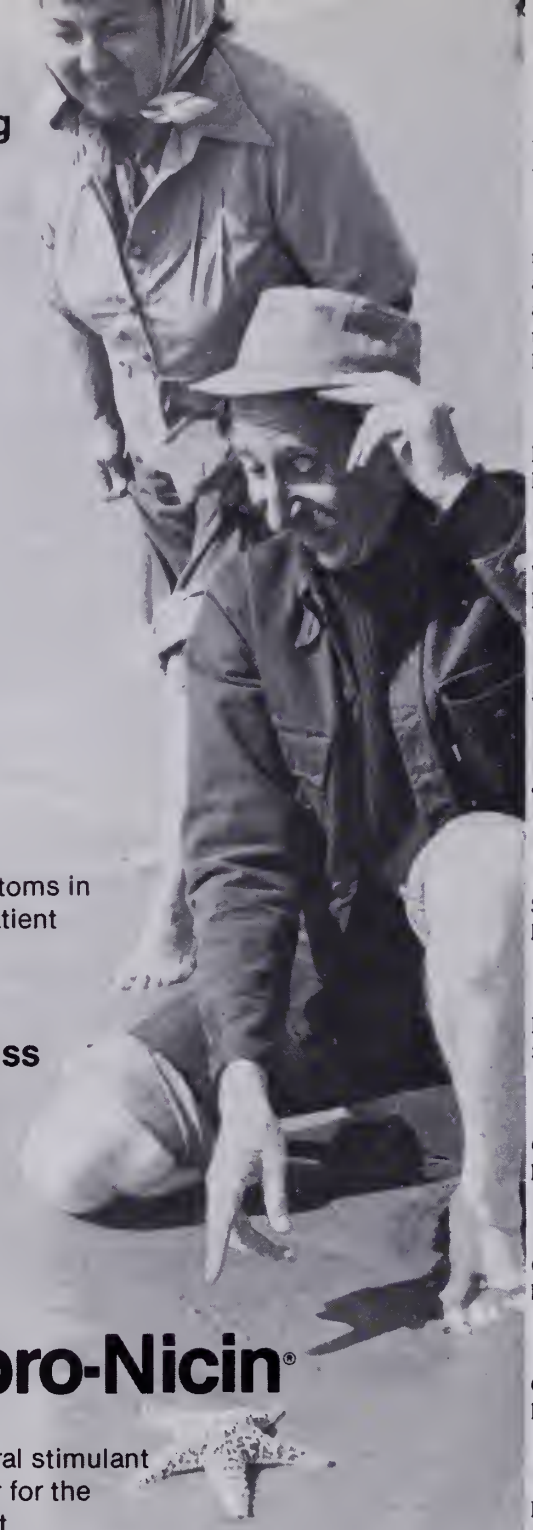
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Books Received

Receipt of the following books is acknowledged. Medical readers interested in reviewing particular books are invited to address requests to the Book Review Editor. Following acceptance of a written review for publication, a reviewer may then retain the book reviewed for his personal or favorite library.

The Chemistry of Human Behavior by Herbert L. Meltzer, Ph.D. 261 Pages. Illustrated. Price $17.95 (cloth). Nelson-Hall Publishers, Chicago, 1979.

Cry Babel, The Nightmare of Aphasia and a Courageous Woman's Struggle to Rebuild Her Life by April O. Armstrong. 252 Pages. Price $8.95. Doubleday & Company, New York, 1979.

Annual Review of Neuroscience with 31 contributing authors. 555 Pages. Annual Reviews, Inc., Palo Alto, California, 1979.

Norethindrone, The First Three Decades edited by Mary Jean Pramik. 100 Pages. Syntex Laboratories, Palo Alto, California, 1978.

Family Health in an Era of Stress conducted by Yankelovich, Skelly and White, Inc. 192 Pages (plus packet). General Mills, Inc., Minneapolis, Minnesota, 1979.

Correlative Neuroanatomy & Functional Neurology, 17th Edition, by Joseph G. Chusid, M.D. 464 Pages. Illustrated. Price $12.00. Lange Medical Publications, Los Altos, California, 1979.

Review of Allied Health Education: 3, Joseph Hamburg, General Editor. 161 Pages. Price $7.50. The University Press of Kentucky, Lexington, Ky., 1979.

Family Health and Home Nursing, American National Red Cross. 626 Pages. Illustrated. Price $3.95. Doubleday & Company, Inc., New York, 1979.

Review of Medical Physiology, 9th Edition, by William F. Ganong, M.D. 618 Pages. Illustrated. $14.00. Lange Medical Publications, Los Altos, California, 1979.

Stop Forgetting by Dr. Bruno Furst. 340 Pages. Price $5.95. Doubleday & Company, Inc., New York, 1979.

How To Improve Your Child's Behavior Through Diet by Laura J. Stevens and Rosemary B. Stoner. 346 Pages. Price $9.95. Doubleday & Company, Inc., New York, 1979.

Helping Hospital Trustees Understand Physicians by Richard E. Thompson, M.D. 82 Pages. Price $9.00. American Hospital Association, Chicago.

Child Guidance by Samuel Kahn, M.D., Ph.D., F.R.S.H. 134 Pages. Price $10.00. Philosophical Library, Inc., New York, 1979.

Current Surgical Diagnosis and Treatment, Fourth Edition by J. Englebert Dunphy, M.D., and Lawrence W. Way, M.D. 1162 Pages. Price $19.00. Lange Medical Publications, Los Altos, California, 1979.

The Vitamin Book by Rich Wentzler. 224 Pages. Price $4.95. Doubleday & Company, Inc., New York, 1979.

The Truth About Senility — And How To Avoid It by Lawrence Galton. 244 Pages. Price $9.95. Thomas Y. Crowell Company, New York, 1979.

Drug Induced Nutritional Deficiencies by Daphne A. Roe, M.D. 272 Pages. The Avi Publishing Company, Inc., Westport, Connecticut, 1978.

Alcohol and the Diet by Daphne A. Roe, M.D. 229 Pages. The Avi Publishing Company, Inc., Westport, Connecticut, 1979.

Cooking Creatively for Your Diabetic Child by Caroline Hastings Babington. 224 Pages. Price $8.95. Doubleday & Company, Inc., New York, 1979.

Vitamin C Against Cancer by H. L. Newbold, M.D. 363 Pages. Price $10.95. Stein and Day, New York, 1979.

Applied Therapeutics for Clinical Pharmacists, Second Edition, Edited by Mary Anne Koda-Kimble, Pharm. D., Brian S. Katcher, Pharm. D., and Lloyd Y. Young, Pharm. D. 944 Pages. Price $31.50. Applied Therapeutics, Inc., San Francisco, 1978.

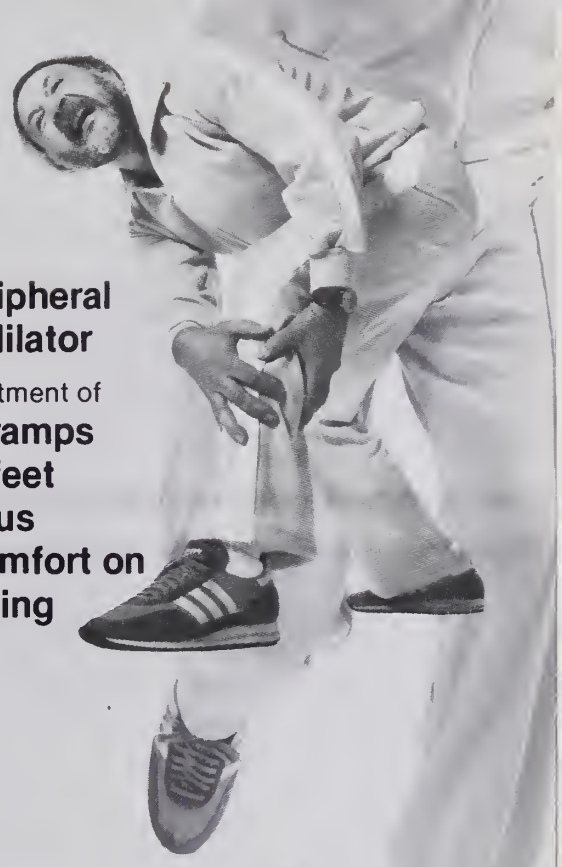
Review of Physiological Chemistry by Harold A. Harper, Ph.D., Victor W. Rodwell, Ph.D., and Peter A. Mayes, Ph.D., D. Sc. 702 Pages. Price $14.50. Lange Medical Publications, Los Altos, California, 1977.

The Heritage of Aviation Medicine, An Annotated Directory of Early Artifacts, by Robert J. Benford, M.D. 122 Pages. Illustrated. Price $4.50. Aerospace Medical Association, Washington, D.C., 1979.

What You Should Know About Medical Lab Tests by Bernard Kliman, M.D. and Raymond Vermette, M.S., with Ernest Kolowrat. 207 Pages. Price $9.95. Thomas Y. Crowell Company, New York, N.Y., 1979.

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Riboflavin (B-2) .....2 mg.
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in a special base of prolonged therapeutic effect.
DOSE: 1 to 2 tablets daily.
AVAILABLE: Bottles of 100, 500.

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LIPO-NICIN®/250 mg.

Each yellow tablet contains:
Nicotinic Acid .....250 mg.
Niacinamide .....75 mg.
Ascorbic Acid .....150 mg.
Thiamine HCL (B-1) .....25 mg.
Riboflavin (B-2) .....2 mg.
Pyridoxine HCL (B-6) .....10 mg.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500.

LIPO-NICIN®/100 mg.

Each blue tablet contains:
Nicotinic Acid .....100 mg.
Niacinamide .....75 mg.
Ascorbic Acid .....150 mg.
Thiamine HCL (B-1) .....25 mg.
Riboflavin (B-2) .....2 mg.
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DOSE: 1 to 5 tablets daily.
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Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN® 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient.

Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur.

Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

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REFER TO PDR





Dr. Rhodin



Dr. Rush

Three important faculty and staff posts . . . at the University of South Florida College of Medicine have been filled.

The new appointments include: Johannes A. G. Rhodin, M.D., Ph.D., as Professor and Chairman of the Department of Anatomy; William E. Rush, M.D., Director of the University of South Florida Medical Clinics; and Frank J. Cozzetto, M.D., Associate Dean for Continuing Medical Education.

A native of Sweden, Dr. Rhodin earned both of his doctorate degrees in that country. He took his medical degree at Karolinska Institute Medical School, where he has been Professor and Chairman of Anatomy since 1977.

The new University of South Florida Department Chairman is an international authority on electron microscopy and has authored more than 100 publications.

Prior to his appointment in Tampa, Dr. Rush was Director of Medical Education at Desert Hospital, Palm Springs, Calif. Before that he was Associate Dean for Curriculum Affairs and Associate Professor of Pediatrics at Wayne State University in Detroit.

Dr. Cozzetto, the new Associate Dean for CME, is a Colorado native and a graduate of the University of Colorado School of Medicine. He was on the pediatric faculty and was an Associate Dean at that school in the early 1970s.

Hollis G. Boren, M.D. . . . has resigned as Dean of the University of South Florida College of Medicine and Director of the USF Medical Center in Tampa, effective January 1. Dr. Boren, who has held the posts since 1977, said he was stepping down because he believed he had accomplished as much as he could.

Andor Szentivanyi, M.D., Associate Dean of Graduate Studies of the College, was named to succeed Dr. Boren on an interim basis. He is also a Professor of Internal Medicine and Professor and Chairman of the Department of Pharmacology and Therapeutics.

A graduate of the University Medical School of Debrecen in Hungary, Dr. Szentivanyi has been at the University of South Florida since 1970.

For the immediate future, Dr. Boren will focus his attention on setting up his research laboratory for continuing work on the response of lungs to chemical carcinogens. He will then resume teaching in the Department of Comprehensive Medicine.

Juan A. del Regato, M.D., of Tampa . . . is the recipient of a prestigious prize for his work in cancer research.

The National Academy of Medicine of Paris announced that Dr. del Regato was the winner of the Prix Bruninghaus for his pioneer work on "the cure of advanced cancer of the prostate by means of radiotherapy exclusively." The prize, bearing the name of Dr. Gena Bruninghaus, is awarded every five years for "the most important work on the etiology or the cure of a cancer."

Dr. del Regato, who began his prize-winning work more than 20 years ago in Colorado Springs, is currently Professor of Radiology at the University of South Florida College of Medicine.

John R. Royer, M.D., of Winter Park . . . has been elected a Trustee of the Southeastern Society of Plastic and Reconstructive Surgeons. A news item in the November 1979 issue of *The Journal* inadvertently omitted mention of Dr. Royer.

The same item listed the Society's Historian, James M. Carraway, M.D., as being from Winter Park. *The Journal* has been advised that the Society's news release was in error and that Dr. Carraway actually is from Norfolk, Va.



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When painful spasm is the presenting symptom . . .



...in the functional bowel/irritable bowel syndrome*

Bentyl®

(dicyclomine hydrochloride USP)

10 mg. capsules, 20 mg. tablets,
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helps control abnormal motor activity with minimal anticholinergic side effects†

Demonstrated smooth muscle relaxant activity.

In this double-blind study, twenty patients having G.I. series and exhibiting spasm were randomly selected to receive either 2 cc. of Bentyl or sodium chloride intramuscularly. Ten minutes after the injection another radiograph was taken . . .

. . . Bentyl produced definite relaxation in 8 of 10 patients. The sodium chloride produced relaxation in only 3 of 10. No side effects occurred in either group of patients.



Pylorospasm has almost totally blocked passage of barium meal.



Barium meal beginning to pass 10 minutes after intramuscular injection of 20 mg. Bentyl.

"The correlation of spasm relief and drug given was excellent."

*This drug has been classified "probably" effective in treating functional bowel/irritable bowel syndrome.

†See Warnings, Precautions and Adverse Reactions.

See following page for prescribing information.

Reference:
King, J.C. and Starkman, N.M.: Evaluation of an antispasmodic. Double-blind evaluation to control gastrointestinal spasms occurring during radiographic examination. A preliminary report. Western Med. 5:356-358, 1964.

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8-4420 (Y736A) MNR-804

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Brief Summary

INDICATIONS

Based on a review of this drug by the National Academy of Sciences–National Research Council and/or other information, FDA has classified the following indications as "probably" effective:

For the treatment of functional bowel/irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS.

For use in the treatment of infant colic (syrup).

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient; unstable cardiovascular status in acute hemorrhage; severe ulcerative colitis; toxic megacolon complicating ulcerative colitis; myasthenia gravis. WARNINGS: In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. PRECAUTIONS: Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy. Use with caution in patients with: Autonomic neuropathy. Hepatic or renal disease. Ulcerative colitis. Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon. Hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension. Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.

Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur. ADVERSE REACTIONS: Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia; urinary hesitancy and retention; blurred vision and tachycardia; palpitations; mydriasis; cycloplegia; increased ocular tension; loss of taste; headache; nervousness; drowsiness; weakness; dizziness; insomnia; nausea; vomiting; impotence; suppression of lactation; constipation; bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation. DOSAGE AND ADMINISTRATION: Dosage must be adjusted to individual patient's needs.

Usual Dosage: Bentyl 10 mg. capsule and syrup: *Adults:* 1 or 2 capsules or teaspoonfuls syrup three or four times daily. *Children:* 1 capsule or teaspoonful syrup three or four times daily. *Infants:* ½ teaspoonful syrup three or four times daily. (May be diluted with equal volume of water.) Bentyl 20 mg.: *Adults:* 1 tablet three or four times daily. Bentyl Injection: *Adults:* 2 ml. (20 mg.) every four to six hours intramuscularly only. NOT FOR INTRAVENOUS USE. MANAGEMENT OF OVERDOSE: The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine® (bethanecol chloride USP) should be used.

Product Information as of October, 1978.

Injectable dosage forms manufactured by CONNAUGHT LABORATORIES, INC., Swiftwater, Pennsylvania 18370 or TAYLOR PHARMACAL COMPANY, Decatur, Illinois 62525 for MERRELL-NATIONAL LABORATORIES, Division of Richardson-Merrell Inc., Cincinnati, Ohio 45215, U.S.A.

Merrell

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MEETINGS

Approved by the FMA Committee on Continuing Medical Education

MARCH

Advanced Cardiac Life Support, Mar. 1-2, Pasco-Hernando Community College, New Port Richey. For information: James M. Marlowe, M.D., Box 249, Elfers, Florida 33531.

Oncology for Family Practitioner and Internist, Mar. 1-8, Caribbean Cruise.*

OB-GYN Caribbean Cruise, Mar. 2-8.*

Basic Neurology for Psychiatrists and Generalists, Mar. 3-7, Konover Hotel, Miami Beach.*

Internal Medicine Update '80, Mar. 3-8, Dutch Inn, Lake Buena Vista. For information: Barry E. Sieger, M.D., Director of Medical Education, Orlando Regional Medical Center, 1414 S. Kuhl Ave., Orlando 32806.

Postgraduate Medical Refresher Course, Mar. 3-14, Galt Ocean Mile Hotel, Ft. Lauderdale. For information: Donald R. Lannin, M.D., 832 Central Medical Building, St. Paul, MN 55104.

Mediclinics, Mar. 3-14, Galt Ocean Mile Hotel, Ft. Lauderdale. For information: Donald R. Lannin, M.D., 832 Central Medical Bldg., St. Paul, MN 55104.

Contact Dermatitis, Mar. 14, Boca Raton Community Hospital, Boca Raton. For information: John P. Kinney, M.D., Box 3167, West Palm Beach 33402.

Diagnostic Radiology for the Emergency & Primary Care Physicians, Mar. 5-9, Pier 66, Ft. Lauderdale. For information: W. T. Haeck, M.D., 3900 N.W. 79th Ave., Suite 469, Miami 33166.

2nd Colonoscopy Congress (The Second International Congress on Colonoscopy and Diseases of the Large Bowel), Mar. 6-8, Americana Hotel, Bal Harbour. For information: John P. Christie, M.D., 7330 S.W. 62nd Place, Suite 220, South Miami 33143.

6th Annual Virginia Apgar Seminar, Obstetric and Pediatric Anesthesia, March 7-9, Americana Hotel, Miami Beach. For information: Dept. of Anesthesia, Mt. Sinai Medical Center, 1200 N.W. 10th Ave., Miami 33136.

***For information: Contact Division of Continuing Medical Education, D23-3, University of Miami School of Medicine, P.O. Box 016960, Miami 33101. Tel. (305) 547-6716.**

****For information: Contact Division of Continuing Education, Box J-233, J. Hillis Miller Health Center, Gainesville 32610. Tel. (904) 392-3143, or 392-3183.**

+For information: Contact Janifer M. Judisch, M.D., CME, University of South Florida, Tampa 33620. Tel. (813) 974-2196.

Critical Pulmonary Care, Mar. 8-9, University of South Florida College of Medicine, Medical Center Auditorium, Tampa. For information: Allan Goldman, M.D., Pulmonary Disease Section (111C), 13000 North 30th St., Tampa 33612.

15th Annual Postgraduate Course in Internal Medicine — 1980, Mar. 9-15, Americana Hotel, Bal Harbour.*

Lumbo-Sacral Disc Disease, Mar. 10, Citrus Memorial Hospital, Inverness. For information: R. Edward Dodge Jr., M.D., 511 W. Highland Blvd., Inverness 32650.

Problems in Rheumatology, March 12-15, Don CeSar Beach Resort Hotel, St. Petersburg Beach. For information: Bernard F. Germain, M.D., Division of Rheumatology, Dept. of Internal Medicine, University of South Florida College of Medicine, Tampa 33612.

Ob-Gyn Cruise Seminar, Mar. 12-24, Aboard the "DORIC".*

Orthopaedics for Family and Emergency Physicians, Mar. 13-15, Dutch Inn, Lake Buena Vista. For information; Allan W. March, M.D., Box J-222, JHM Health Center, Gainesville 32610.

14th Annual American Cancer Society Clinical Cytopathology, Workshop, Mar. 14-15, Eckerd College, St. Petersburg. For information: Ira Evans, M.D., c/o American Cancer Society, Pinellas County Unit, 1001 S. McDill Ave., Tampa 33609.

Diagnostic Therapeutics XVIII—Acid Base, Fluids and Electrolytes Therapy; Blood Gases, Mar. 14-15, Doctors' Club and Study Center, The Hilton Inn & Conference Center at Inverrary, Ft. Lauderdale. For information: Doctors's Club, The Hilton Inn & Conference Center at Inverrary, 3501 Inverrary Blvd., Suite 106, Ft. Lauderdale 33319.

11th Annual Topics in Internal Medicine, March 20-22, Gainesville Hilton, Gainesville.**

6th Annual Postgraduate Seminar in I.V. and I.M. Dental Sedation, March 20-23, Americana Hotel, Miami Beach. For information: Dept. of Anesthesiology, Mt. Sinai Medical Center, 1200 N.W. 10th Ave., Miami 33136.

Oral and Maxillofacial Surgery Seminar, Mar. 22-23, Bal Harbour.*

Hepatobiliary Disease, Mar. 27-29, Americana Hotel, Bal Harbour.*

Critical Care Medicine 1980, Mar. 27-29, Dutch Inn, Lake Buena Vista. For information: Barry E. Sieger, M.D., Director of Medical Education, Orlando Regional Medical Center, 1414 S. Kuhl Ave., Orlando 32806.

Perinatology III, Current Trends in Maternal and Neonatal Care, Mar. 27-29, Hyatt House, Orlando.**

Current Clinical Concepts in Otolaryngology, Mar. 27-29, Americana Hotel, Bal Harbour.*

13th Annual Physicians Workshop in EKG, Mar. 29 - Apr. 3, Mexico City, Mexico. For information: Henry J. L. Marriott, M.D., Rogers Heart Foundation, St. Anthony's Hospital, St. Petersburg 33705.

11th Family Practice Review, March 31-April 4, Orlando Hyatt Hotel, Kissimmee.**

APRIL

Diagnostic Therapeutics XVIX—Ophthalmology: Extracapsular Cataract Surgery and Implants, Apr. 5-6, Doctors' Club & Study Center, The Hilton Inn & Conference Center at Inverrary, Ft. Lauderdale. For information: Doctors's Club, The Hilton Inn & Conference Center at Inverrary, 3501 Inverrary Blvd., Suite 106, Ft. Lauderdale 33319.

Skin Cancer: Recognition, Pathology and Treatment of Squamous and Basal Cell Cancer, Apr. 8, Victoria Hospital, Miami.*

The Clinical Approach to Exercise Testing, Apr. 10-12, Sheraton Sand Key, Clearwater. +

Second Annual Holmes Regional Medical Center Symposium Trauma, Apr. 11-12, Holmes Regional Medical Center, Melbourne. For information: Pat B. Unger, M.D., 1281 S. Hickory St., Melbourne 32901.

Cardiac Rehabilitation, Apr. 11-13, Hyatt House, Orlando. For information: International Medical Education Corp., Div. of Postgraduate Education, Dept. 12, 64 Inverness Dr. E., Englewood, CA 80112.

Gastroenterology - 1980, Apr. 18-20, Orlando Marriott Inn, Orlando.**

Echocardiography In-Service Workshop, Apr. 21-25, Jackson Memorial Medical Center, Miami.*

Endocrinology and Diabetes '80, Apr. 25-26, Dutch Inn, Lake Buena Vista. For information: Barry E. Sieger, M.D., Director of Medical Education, Orlando Regional Medical Center, 1414 South Kuhl Ave., Orlando 32806.

8th Annual Intensive Care Symposium, Apr. 25-28, Eden Roc Hotel, Miami Beach.*

Update on Inhalation Anesthesia—Progress and Concepts of the Past Decade, Apr. 26-27, Marriott Hotel, New Orleans, LA. For information: Warren W. Sears, M.D., 1717 North E Street, Suite 205, Pensacola 32501.

MAY

Pediatric Ophthalmology, May 1-3, Don CeSar Hotel, St. Petersburg Beach.+

Principles of Cosmetics for the Dermatologist: 1980, May 1-3, Omni International Hotel, Miami. For information: Ms. Esther Cohen, CME Coordinator, Mt. Sinai Medical Center, 4300 Alton Rd., Miami Beach 33140.

Update on Hormone Replacement, May 12, Citrus Memorial Hospital, Inverness. For information: R. Edward Dodge Jr., M.D., 511 W. Highland Blvd., Inverness 32650.

Designing A Program for the Management of Arthritis, May 13, Manatee Memorial Hospital Auditorium, Bradenton. For information: Leonides Y. Teves, M.D. 706 39th St., W., Bradenton 33505.

A Symposium: Refracting and Prescribing (Ophthalmology), May 16, Gainesville Hilton, Gainesville.**

Seminar on Hypertension and Renal Disease (in Spanish), May 16-17, Konover Hotel, Miami Beach.*

Nuclear Medicine and Radioassay Training Seminar, May 26-30, Miami.*

Master Approach to Cardiovascular Problems — 8th Annual Conference, May 30-June 1, Contemporary Hotel, Disney World, Lake Buena Vista. For information: Yolanda Barcena, Department of Cardiology, P.O. Box 016960, Miami 33101.

JUNE

Bascom Palmer Eye Institute, Resident's Day, June, Miami.*

Annual Homecoming in Psychiatry, June. Miami.*

Cardiology for the Practitioner, June 4-6, The Breakers, Palm Beach.**

Fifth Annual Florida Suncoast Pediatric Conference, June 15-18, Sheraton Sand Key Hotel, Clearwater. For information: Donald I. Macdonald, M.D., 801 Sixth St., S., St. Petersburg 33701.

MKSAP-V (Internal Medicine Review) (American College of Physicians), June 23-27, The Dutch Inn, Lake Buena Vista.**

JULY

Coronary Disease, Exercise Teastin, and Cardiac Rehabilitation, July 11-13, Orlando Hyatt, Orlando. For information: International Medical Education Corp., Division of Postgraduate Education, Dept. 12, 64 Inverness Dr., E., Englewood, Colorado 80112.

Ventricular Arrhythmias, July 14, Citrus Memorial Hospital, Inverness. For information: R. Edward Dodge Jr., M.D., 511 W. Highland Blvd., Inverness 32650.

5th Canadian Summer Workshop in EKG, July 19-22, Edmonton, Alberta, Canada, For information: Henry J. L. Marriott, M.D., Rogers Heart Foundation, St. Anthony's Hospital, St. Petersburg 33705.

AUGUST

Fundamental and Clinical Aspects of Internal Medicine, Aug. 1980.*

EKG Interpretation and Arrhythmia Management, Aug. 22-24, Dutch Inn, Lake Buena Vista. For information: International Medical Education Corp., Division of Postgraduate Education, Dept. 12, 64 Inverness Dr., E., Englewood, Colorado 80112.

18th Annual Seminar in Cardiology, Aug. 30-Sept. 6, Copenhagen, Denmark. For information: Henry J. L. Marriott, M.D., Rogers Heart Foundation. St. Anthony's Hospital, St. Petersburg 33705.

SEPTEMBER

Dermatology in Florida, Sept. 8, Citrus Memorial Hospital, Inverness. For information: R. Edward Dodge Jr., M.D., 511 W. Highland Blvd. Inverness 32650.

OCTOBER

Echocardiography In-Service Workshop, Oct. 20-24, University of Miami, Jackson Memorial Medical Center, Miami.*

NOVEMBER

Vascular Lesion of CNS, Nov. 10, Citrus Memorial Hospital, Inverness. For information: R. Edward Dodge Jr., M.D., 511 W. Highland Blvd., Inverness 32650.



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Contraindications: Tablets in children under 6 months of age; known hypersensitivity; acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.

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***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations, as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

ORAL Advise patients against simultaneous ingestion of alcohol and other CNS depressants.

Not of value in treatment of psychotic patients; should not be employed in lieu of appropriate treatment. When using oral form adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increase in dosage of standard anticonvulsant medication; abrupt withdrawal in such cases may be associated with temporary increase in frequency and/or severity of seizures.

INJECTABLE. *To reduce the possibility of venous thrombosis, phlebitis, local irritation, swelling, and, rarely, vascular impairment when used I.V. inject slowly, taking at least one minute for each 5 mg (1 ml) given; do not use small veins, i.e., dorsum of hand or wrist, use extreme care to avoid intra-arterial administration or extravasation. Do not mix or dilute Valium with other solutions or drugs in syringe or infusion flask. If it is not feasible to administer Valium directly I.V., it may be injected slowly through the infusion tubing as close as possible to the vein insertion.*

Administer with extreme care to elderly, very ill, those with limited pulmonary reserve because of possibility of apnea and/or cardiac arrest, concomitant use of barbiturates, alcohol or other CNS depressants increases depression with increased risk of apnea, have resuscitative facilities available. When used with narcotic analgesic eliminate or reduce narcotic dosage at least 1/3, administer in small increments. Should not be administered to patients in shock, coma, acute alcoholic intoxication with depression of vital signs.

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Efficacy/safety not established in neonates (age 30 days or less); prolonged CNS depression observed. In children, give slowly (up to 0.25 mg/kg over 3 minutes) to avoid apnea or prolonged somnolence; can be repeated after 15 to 30 minutes. If no relief after third administration, appropriate adjunctive therapy is recommended.

Precautions: If combined with other psychotropics or anticonvulsants, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of Valium (diazepam), *i.e.*, phenothiazines, narcotics, barbiturates, MAO inhibitors and antidepressants. Protective measures indicated in highly anxious patients with accompanying depression who may have suicidal tendencies. Observe usual precautions in impaired hepatic function; avoid accumulation in patients with compromised kidney function. Limit oral dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation (initially 2 to 2½ mg once or twice daily, increasing gradually as needed or tolerated).

INJECTABLE Although promptly controlled, seizures may return; readminister if necessary, not recommended for long-term maintenance therapy Laryngospasm/increased cough reflex are possible during peroral endoscopic procedures; use topical anesthetic, have necessary countermeasures available. Hypotension or muscular weakness possible, particularly when used with narcotics, barbiturates or alcohol. Use lower doses (2 to 5 mg) for elderly/debilitated.

Adverse Reactions: Side effects most commonly reported were drowsiness, fatigue, ataxia Infrequently encountered were confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo, blurred vision Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances and stimulation have been reported, should these occur, discontinue drug

Because of isolated reports of neutropenia and jaundice, periodic blood counts, liver function tests advisable during long-term therapy Minor changes in EEG patterns, usually low-voltage fast activity, have been observed in patients during and after Valium (diazepam) therapy and are of no known significance

INJECTABLE Venous thrombosis/phlebitis at injection site, hypoactivity, syncope, bradycardia, cardiovascular collapse, nystagmus, urticaria, hiccups, neutropenia

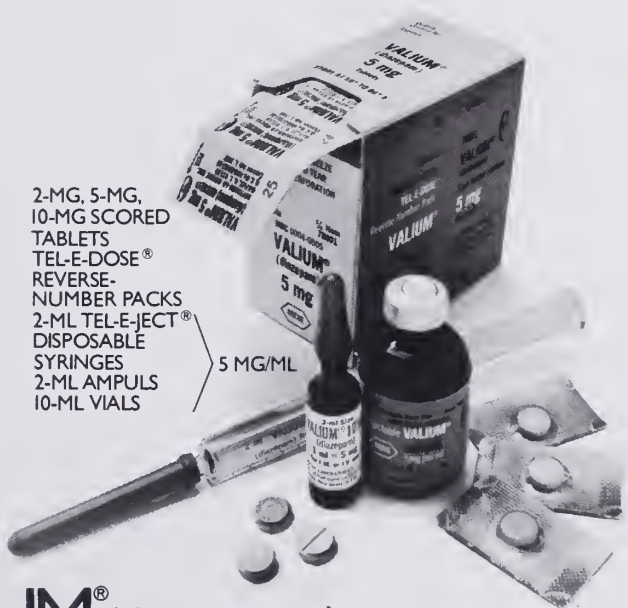
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Management of Overdosage: Manifestations include somnolence, confusion, coma, diminished reflexes Monitor respiration, pulse, blood pressure, employ general supportive measures, I V fluids, adequate airway Use levarterenol or metaraminol for hypotension, caffeine and sodium benzoate for CNS-depressive effects Dialysis is of limited value

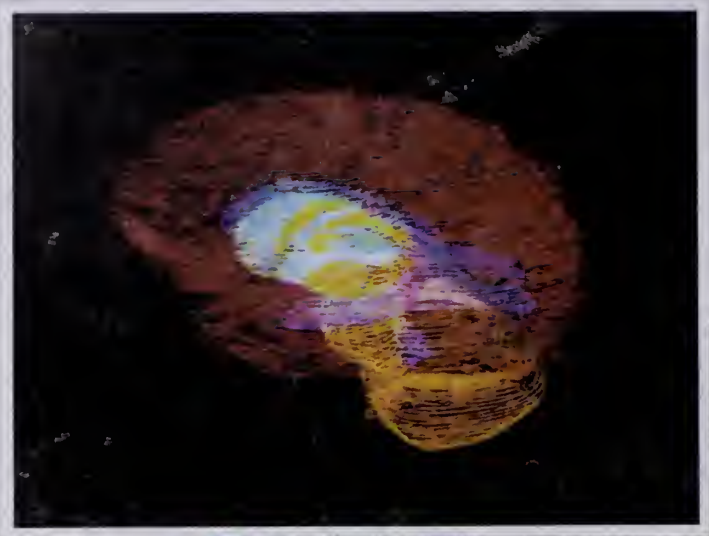
Supplied: Tablets, 2 mg, 5 mg and 10 mg, bottles of 100 and 500, Tel-E-Dose® (unit dose) packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10, Prescription Paks of 50, available singly and in trays of 10. Ampuls, 2 ml, boxes of 10, Vials, 10 ml, boxes of 1, Tel-E-Ject® (disposable syringes), 2 ml, boxes of 10 Each ml contains 5 mg diazepam, compounded with 40% propylene glycol, 10% ethyl alcohol, 5% sodium benzoate and benzoic acid as buf - ers, and 1.5% benzyl alcohol as preservative

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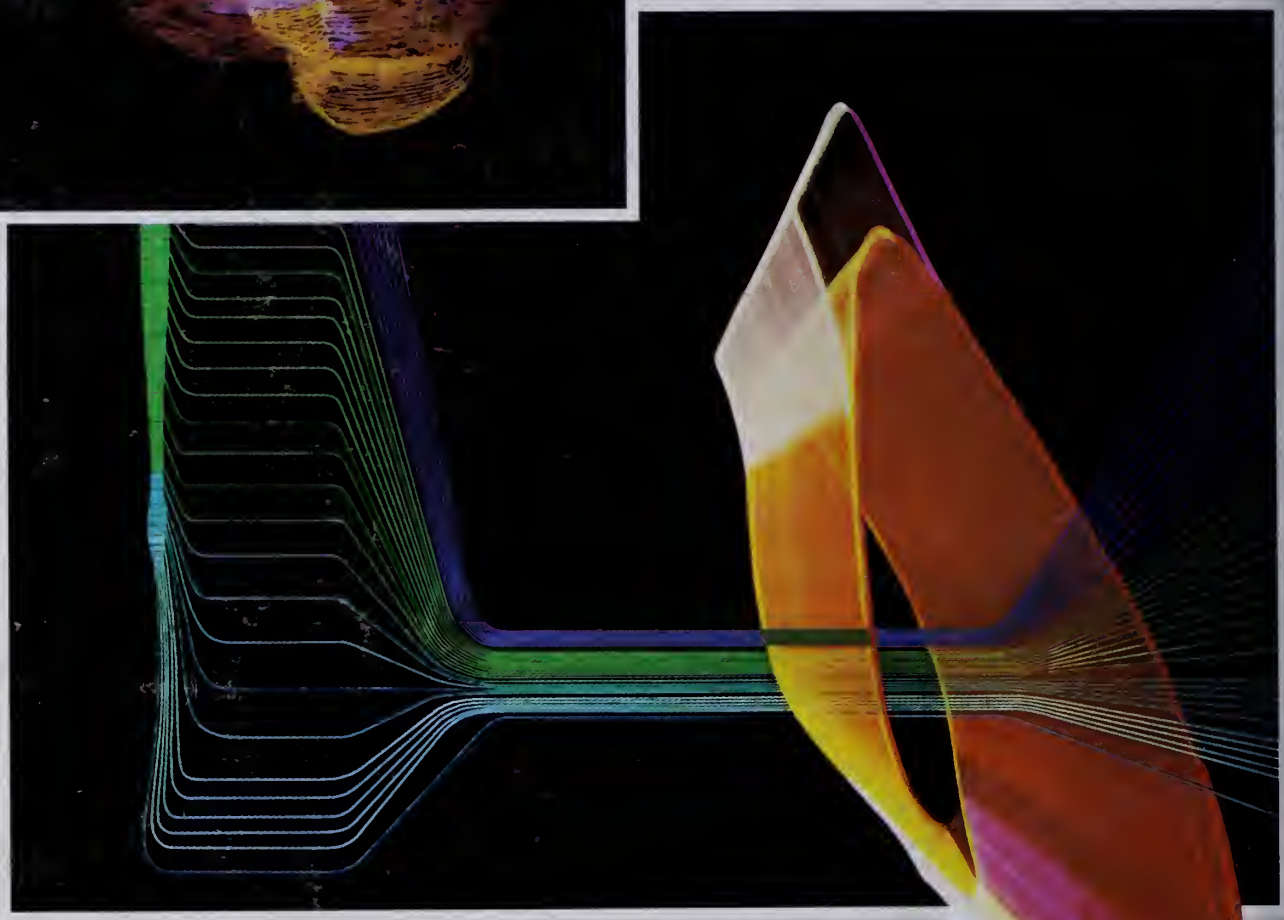


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preceding page for a summary of product information.

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MARCH 1980 • VOL 67 • NO. 3

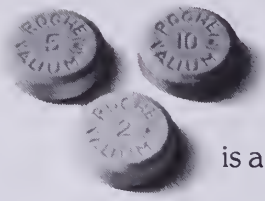
SPECIAL ISSUE

University of Florida College of Medicine

GUEST EDITOR

J. Lee Dockery, M.D.

A character all its own.



Valium (diazepam/Roche) is a benzodiazepine with a character all its own. Pharmacologically, it is a potent skeletal muscle relaxant and anticonvulsant (in adjunctive use), as well as an antianxiety agent. Pharmacokinetically, only Valium provides active *diazepam* as well as the active metabolites 3-hydroxydiazepam, desmethyldiazepam and oxazepam.

But the individual character of Valium is even more apparent clinically than pharmacokinetically. And far more significant. That's because of the patient response obtained with Valium. A response which brings a calmer frame of mind. A response which has a pronounced effect on the somatic symptoms of anxiety, particularly muscular tension. A response which helps the patient feel more like himself again because of the way Valium reduces the overwhelming symptoms of anxiety and psychic tension.

Another important aspect of the clinical character of Valium is safety. Though drowsiness, ataxia and fatigue are possible, these and more serious side effects are rarely a problem. Of course, as with all CNS-acting drugs, patients taking Valium should be cautioned against driving, operating dangerous machinery or the simultaneous ingestion of alcohol.

Unquestionably, many psychotherapeutic agents, including other benzodiazepines, have antianxiety effects. But one fact remains: you get a certain kind of patient response with Valium. It's a response you want. A response you know. A response you trust as part of your overall management of anxiety and psychic tension.

Valium® (IV)
diazepam/Roche

2-mg, 5-mg, 10-mg scored tablets

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Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10.

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The cover picture was photographed by Johnson F tography of Gainesville, Florida. Mr. Sam Johnson, ow donated the cover in honor of the 20th reunion of University of Florida College of Medicine. The Universi very appreciative of this important contribution. Som you may remember Mr. Johnson from the College Medicine Class of 1966 before he decided to "specialize photography. His son, Samuel W. Johnson IV photograp and processed the cover photograph.

SPECIAL ISSUE

University of Florida College of Medicine

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CONTRAINDICATIONS Use in Newborn or Premature infants. This drug should not be used in newborn or premature infants.

Use in Nursing Mothers. Because of the higher risk of antihistamines for infants generally and for newborns and prematures in particular, antihistamine therapy is contraindicated in nursing mothers.

Use in Lower Respiratory Disease. Antihistamines should NOT be used to treat lower respiratory tract symptoms including asthma

Antihistamines are also contraindicated in the following conditions: hypersensitivity to azatadine maleate and other antihistamines of similar chemical structure; monoamine oxidase inhibitor therapy (See DRUG INTERACTIONS Section).

WARNINGS Antihistamines should be used with considerable caution in patients with: narrow angle glaucoma, stenosing peptic ulcer, pyloroduodenal obstruction, symptomatic prostatic hypertrophy, bladder neck obstruction

Use in Children. In infants and children especially, antihistamines in overdosage may cause hallucinations, convulsions, or death

As in adults, antihistamines may diminish mental alertness in children. In the young child, particularly, they may produce excitation

OPTIMINE TABLETS ARE NOT INTENDED FOR USE IN CHILDREN UNDER 12 YEARS OF AGE.

Use in Pregnancy. Experience with this drug in pregnant women is inadequate to determine whether there exists a potential for harm to the developing fetus

Use with CNS Depressants. Azatadine maleate has additive effects with alcohol and other CNS depressants (hypnotics, sedatives, tranquilizers, etc.)

Use in Activities Requiring Mental Alertness. Patients should be warned about engaging in activities requiring mental alertness, such as driving a car or operating appliances, machinery, etc.

Use in the Elderly (approximately 60 years or older): Antihistamines are more likely to cause dizziness, sedation, and hypotension in elderly patients.

PRECAUTIONS Azatadine maleate has an atropine-like action and, therefore, should be used with caution in patients with a history of bronchial asthma, increased intraocular pressure, hyperthyroidism, cardiovascular disease; hypertension.

DRUG INTERACTIONS MAO inhibitors prolong and intensify the anticholinergic (drying) effects of antihistamines

ADVERSE REACTIONS The most frequent adverse reactions are underlined

General: Urticaria, drug rash, anaphylactic shock, photosensitivity, excessive perspiration, chills, dryness of mouth, nose, and throat.

Cardiovascular System: Hypotension, headache, palpitations, tachycardia, extrasystoles

Hematologic System: Hemolytic anemia, thrombocytopenia, agranulocytosis

Nervous System: Sedation, sleepiness, dizziness, disturbed coordination, fatigue, confusion, restlessness, excitation, nervousness, tremor, irritability, insomnia, euphoria, paresthesias, blurred vision, diplopia, vertigo, tinnitus, acute labyrinthitis, hysteria, neuritis, convulsions

Gastrointestinal System: Epigastric distress, anorexia, nausea, vomiting, diarrhea, constipation

Genitourinary System: Urinary frequency, difficult urination, urinary retention, early menses.

Respiratory System: Thickening of bronchial secretions, tightness of chest and wheezing, nasal stuffiness.

OVERDOSAGE Antihistamine overdosage reactions may vary from central nervous system depression to stimulation. Stimulation is particularly likely in children. Atropine-like signs and symptoms (dry mouth, fixed, dilated pupils; flushing, and gastrointestinal symptoms) may also occur

If vomiting has not occurred spontaneously, the patient should be induced to vomit. This is best done by having him drink a glass of water or milk after which he should be made to gag. Precautions against aspiration must be taken, especially in infants and children

If vomiting is unsuccessful, gastric lavage is indicated within three hours after ingestion and even later if large amounts of milk or cream were given beforehand. Isotonic and ½ isotonic saline is the lavage solution of choice

Saline cathartics, such as milk of magnesia, draw water into the bowel by osmosis and therefore are valuable for their action in rapid dilution of bowel content

Stimulants should not be used

Vasopressors may be used to treat hypotension.

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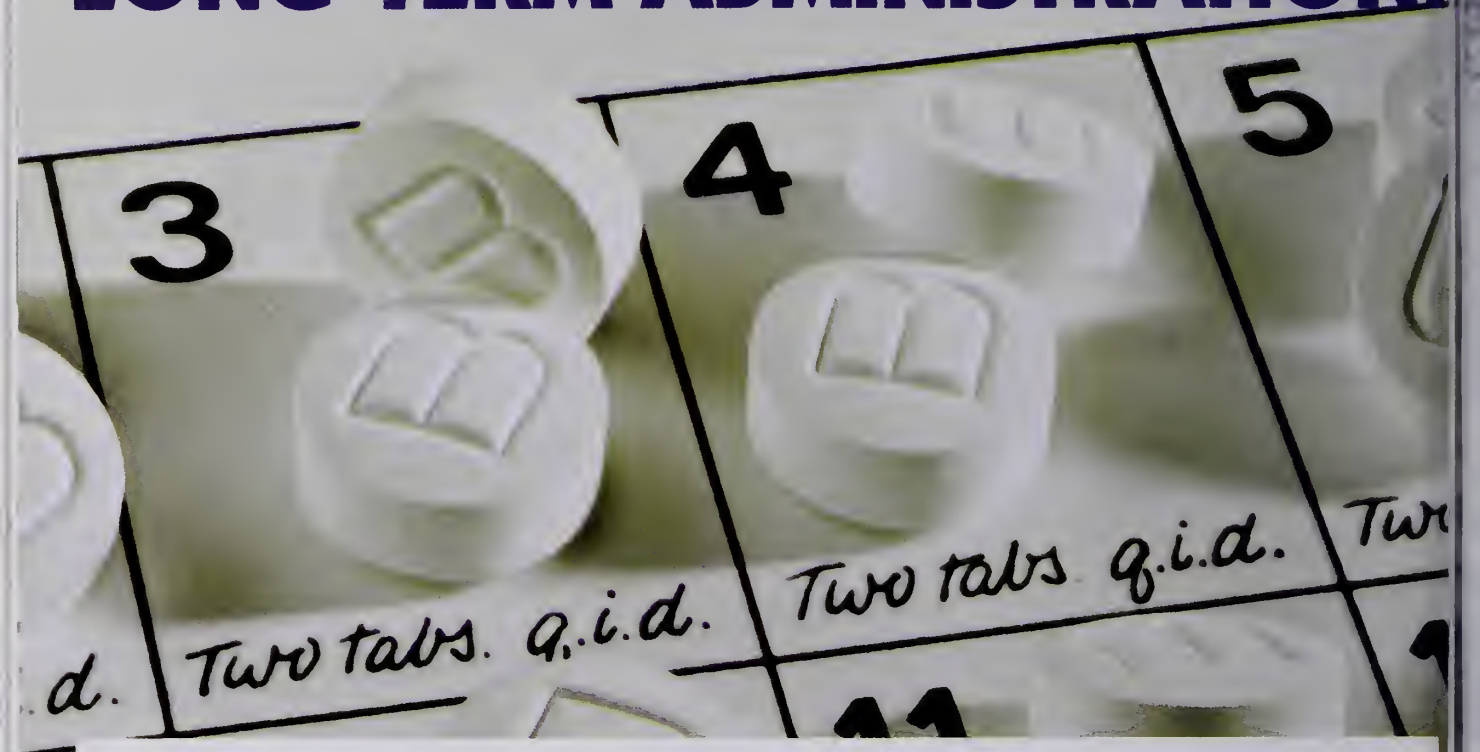
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V-Cillin K®
penicillin V potassium

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Contraindication: Previous hypersensitivity to penicillin.

Warnings: Serious, occasionally fatal, anaphylactoid reactions have been reported. Some patients with penicillin hypersensitivity have had severe reactions to a cephalosporin; inquire about penicillin, cephalosporin, or other allergies before treatment. If an allergic reaction occurs, discontinue the drug and treat with the usual agents (e.g., epinephrine or other pressor amines, antihistamines, or corticosteroids).

Precautions: Use with caution in individuals with histories of significant allergies and/or asthma. Do not rely on oral administration in patients with severe illness, nausea, vomiting, gastric dilatation, cardiospasm, or intestinal hypermotility. Occasional patients will not absorb therapeutic amounts given orally. In streptococcal infections, treat until the organism is eliminated (minimum of ten days). With prolonged use, nonsusceptible organisms, including fungi, may overgrow; treat superinfection appropriately.

Adverse Reactions: Hypersensitivity, including fatal anaphylaxis. Nausea, vomiting, epigastric distress, diarrhea, and black, hairy tongue. Skin eruptions, urticaria, reactions resembling serum sickness (including chills, edema, arthralgia, prostration), laryngeal edema, fever, and eosinophilia. Infrequent hemolytic anemia, leukopenia, thrombocytopenia, neuropathy, and nephropathy, usually with high doses of parenteral penicillin. [102175]

***Equivalent to penicillin V.**

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Professional Liability Legal Update

Sovereign Immunity — Municipal Hospitals

In a personal injury action, plaintiff sued a municipal hospital, a corporation which operated the emergency room at the hospital and the doctor who had treated him, alleging negligence in his treatment following injuries received by plaintiff when he fell through a glass storm door. The city moved for summary judgement, contending that plaintiff had failed to state a claim upon which relief could be granted, because the city, as a governmental agency engaged in the exercise or discharge of a governmental function, was immune from tort liability under Michigan statutory law. The Michigan Supreme Court granted leave to consider whether the day to day operation of a hospital was a "governmental function" as that phrase was used in the sovereign immunity statute.

In striking down governmental immunity as applied to municipal hospitals, the Michigan Supreme Court stated that "the operation of a hospital is a noble undertaking on the part of a unit of government. But, the fact that the government-operated hospital contributes to the 'common good' does not distinguish the government-operated hospital from the non-government-hospital. We feel safe in assuming that hospitals operated by non-government entities, who do not enjoy immunity from tort liability, also contribute to the 'common good'. The modern hospital, whether operated by a city, a church, or a group of private investors, is essentially a business. As such, there is no rationale ground upon which immunity for the government-operated hospital can rest." *Parker v. City of Highland Park* 273 N.W. 2d 413 (Mich. 1978).

Responsibility for Nurse's Negligence

Plaintiff sued the defendant hospital contending that it was liable to her for the actions of a nurse who was allegedly negligent in the administration of drugs to the patient, and in prematurely assisting the patient in her release from the hospital. The hospital moved for summary judgement on the grounds that the nurse was not the hospital's agent and that it was, therefore, not liable for any acts or omissions on her part. The trial court granted a summary judgement in favor of the hospital, and the plaintiff appealed.

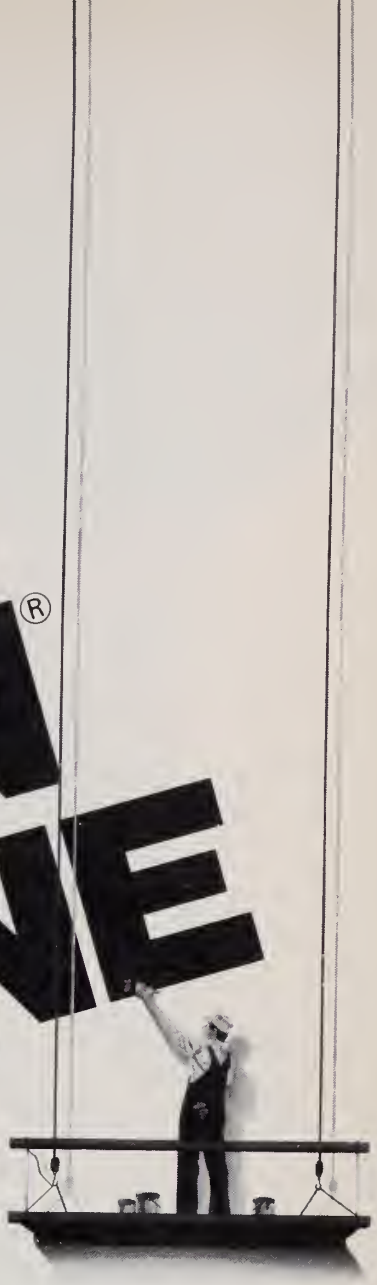
On appeal, the First District Court of Appeal upheld the trial court's ruling, holding that the acts of the nurse upon which liability was alleged to exist were not the acts of an agent of the hospital, so that the hospital was not liable through her based upon the doctrine of respondeat superior. The Court distinguished the case of *Buzan v. Mercy Hospital* where the surgical nurse who incorrectly counted the sponges during the plaintiff's operation was acting as the hospital's agent in that capacity because "furnishing proper personnel and equipment for an operation are duties of a hospital", and the nurse was acting under orders of the hospital, not "under the orders of the private physician in matters involving professional skill and decision . . ." In this case, the Court found that the nurse was acting under the attending physician's orders in administering a drug to the patient and in assisting her temporary release from the hospital. Such actions were held to be the direct result of the attending physician's professional decisions and had nothing to do with administerial, administrative duties of the hospital. *Burroughs v. Board of Trustees of Alachua General Hospital,* Fla. 1st DCA, Case No. NN-310, Dec. 11, 1979).

Prepared and submitted by John E. Thrasher, J.D., Vice President and Legal Counsel, and Anthony J. McNicholas III, J.D., Associate Legal Counsel, Professional Insurance Management Co. (PIMCO), Jacksonville, Fla.

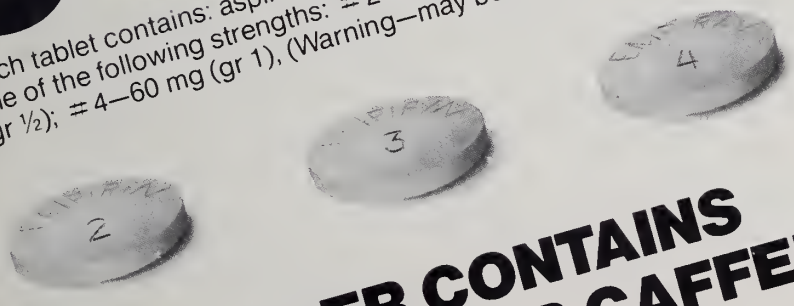
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dual-action **Triavil**®

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containing perphenazine and amitriptyline HCl

helps patients get back to business

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TRIAVIL® 4-50: Each tablet contains
4 mg perphenazine and 50 mg amitriptyline HCl.
TRIAVIL® 4-25: Each tablet contains
4 mg perphenazine and 25 mg amitriptyline HCl.
TRIAVIL® 4-10: Each tablet contains
4 mg perphenazine and 10 mg amitriptyline HCl.

CONTRAINDICATIONS: Central nervous system depression from drugs (barbiturates, alcohol, narcotics, analgesics, antihistamines); evidence of bone marrow depression; known hypersensitivity to phenothiazines or amitriptyline. Should not be given concomitantly with a monoamine oxidase inhibitor since hyperpyretic crises, severe convulsions, and deaths have occurred from such combinations. When used to replace a monoamine oxidase inhibitor, allow a minimum of 14 days to elapse before initiating therapy with TRIAVIL. Therapy should then be initiated cautiously with gradual increase in dosage until optimum response is achieved. Not recommended for use during acute recovery phase following myocardial infarction.

WARNINGS: TRiAVIL should not be given concomitantly with guanethidine or similarly acting compounds since TRIAVIL may block the antihypertensive action of such compounds. Use cautiously in patients with history of urinary retention, angle-closure glaucoma, increased intraocular pressure, or convulsive disorders. Dosage of anticonvulsive agents may have to be increased. In patients with angle-closure glaucoma, even average doses may precipitate an attack. Patients with cardiovascular disorders should be watched closely. Tricyclic antidepressants, including amitriptyline HCl, have been reported to produce arrhythmias, sinus tachycardia, and prolongation of conduction time, particularly in high doses. Myocardial infarction and stroke have been reported with tricyclic antidepressant drugs. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. May impair mental and/or physical abilities required for performance of hazardous tasks, such as operating machinery or driving a motor vehicle. In patients who use alcohol excessively, potentiation may increase the danger inherent in any suicide attempt or overdosage. Not recommended in children or during pregnancy.

PRECAUTIONS: Suicide is a possibility in depressed patients and may remain until significant remission occurs. Such patients should not have access to large quantities of this drug.

Perphenazine: Should not be used indiscriminately. Use with caution in patients who have previously exhibited severe adverse reactions to other phenothiazines. Likelihood of some untoward actions is greater with high doses. Closely supervise with any dosage. The antiemetic effect of perphenazine may obscure signs of toxicity due to overdosage of other drugs or make more difficult the diagnosis of disorders such as brain tumor or intestinal obstruction. A significant, not otherwise explained, rise in body temperature may suggest individual intolerance to perphenazine, in which case discontinue.

If hypotension develops, epinephrine should not be employed, as its action is blocked and partially reversed by perphenazine. Phenothiazines may potentiate the action of central nervous system depressants (opiates, analgesics, antihistamines, barbiturates, alcohol) and atropine. In concurrent therapy with any of these, TRIAVIL should be given in reduced dosage. May also potentiate the action of heat and phosphorous insecticides. There is sufficient experimental evidence to conclude that chronic administration of antipsychotic drugs which increase prolactin secretion has the potential to induce mammary neoplasms in rodents under the appropriate conditions. There are recognized differences in the physiological role of prolactin between rodents and humans. Since there are, at present, no adequate epidemiological studies, the relevance to human mammary cancer risk from prolonged exposure to perphenazine and other antipsychotic drugs is not known.

Amitriptyline: In manic-depressive psychosis, depressed patients may experience a shift toward the manic phase if they are treated with an antidepressant. Patients with paranoid symptomatology may have an exaggeration of such symptoms. The tranquilizing effect of TRIAVIL seems to reduce the likelihood of this effect. When amitriptyline HCl is given with anticholinergic agents or sympathomimetic drugs, including epinephrine combined with local anesthetics, close supervision and careful adjustment of dosages are required. Paralytic ileus may occur in patients taking tricyclic antidepressants in combination with anticholinergic-type drugs.

Caution is advised if patients receive large doses of ethchlorvynol concurrently. Transient delirium has been reported in patients who were treated with 1 g of ethchlorvynol and 75-150 mg of amitriptyline HCl.

Amitriptyline HCl may enhance the response to alcohol and the effects of barbiturates and other CNS depressants.

Concurrent administration of amitriptyline HCl and electroshock therapy may increase the hazards associated with such therapy. Such treatment should be limited to patients for whom it is essential. Discontinue several days before elective surgery if possible. Elevation and lowering of blood sugar levels have both been reported. Use with caution in patients with impaired liver function.

ADVERSE REACTIONS: Similar to those reported with either constituent alone.
Perphenazine: Extrapyramidal symptoms (opisthotonus, oculogyric crisis, hyperreflexia, dystonia, akathisia, acute dyskinesia, ataxia, parkinsonism) have been reported and can usually be controlled by the concomitant use of effective antiparkinsonian drugs and/or by reduction in dosage, but sometimes persist after discontinuation of the phenothiazine.

Tardive dyskinesia may appear in some patients on long-term therapy or may occur after drug therapy with phenothiazines and related agents has been discontinued. The risk appears to be greater in elderly patients on high-dose therapy, especially females. Symptoms are persistent and in some patients appear to be irreversible. The syndrome is characterized by rhythmical involuntary movements of the tongue, face, mouth, or jaw. Involuntary movements of the extremities sometimes occur. There is no known treatment for tardive dyskinesia; antiparkinsonism agents usually do not alleviate the symptoms. It is advised that all antipsychotic agents be discontinued if the above symptoms appear. If treatment is reinstituted, or dosage of the particular drug increased, or another drug substituted, the syndrome may be masked. Fine vermicular movements of the tongue may be an early sign of the syndrome. The full-blown syndrome may not develop if medication is stopped when lingual vermiculation appears.

Other side effects are skin disorders (photosensitivity, itching, erythema, urticaria, eczema, up to exfoliative dermatitis); other allergic reactions (asthma, laryngeal edema, angioneurotic edema, anaphylactoid reactions); peripheral edema; reversed epinephrine effect; hyperglycemia; endocrine disturbances (lactation, galactorrhea, gynecomastia, disturbances of menstrual cycle); altered cerebrospinal fluid proteins; paradoxical excitement; hypertension, hypotension, tachycardia, and ECG abnormalities (quinidine-like effect); reactivation of psychotic processes; catatonic-like states; autonomic reactions, such as dry mouth or salivation, headache, anorexia, nausea, vomiting, constipation, obstipation, urinary frequency or incontinence, blurred vision, nasal congestion, and a change in pulse rate; other adverse reactions reported with various phenothiazine compounds, but not with perphenazine, include grand mal convulsions, cerebral edema, polyphagia, pigmentary retinopathy, photophobia, skin pigmentation, and failure of ejaculation.

The phenothiazine compounds have produced blood dyscrasias (pancytopenia, thrombocytopenic purpura, leukopenia, agranulocytosis, eosinophilia) and liver damage (jaundice, biliary stasis).

Pigmentation of the cornea and lens has been reported to occur after long-term administration of some phenothiazines. Although it has not been reported in patients receiving TRIAVIL, the possibility that it might occur should be considered.

Hypnotic effects, lassitude, muscle weakness, and mild insomnia have also been reported.

Amitriptyline: Note: Listing includes a few reactions not reported for this drug, but which have occurred with other pharmacologically similar tricyclic antidepressant drugs and must be considered when amitriptyline is administered. *Cardiovascular:* Hypotension; hypertension; tachycardia; palpitation; myocardial infarction; arrhythmias; heart block; stroke. *CNS and Neuromuscular:* Confusional states; disturbed concentration; disorientation; delusions; hallucinations; excitement; anxiety; restlessness; insomnia; nightmares; numbness, tingling, and paresthesias of the extremities; peripheral neuropathy; incoordination; ataxia; tremors; seizures; alteration in EEG patterns; extrapyramidal symptoms; tinnitus; syndrome of inappropriate ADH (antidiuretic hormone) secretion. *Anticholinergic:* Dry mouth; blurred vision; disturbance of accommodation; increased intraocular pressure; constipation; paralytic ileus; urinary retention; dilatation of urinary tract. *Allergic:* Skin rash; urticaria; photosensitization; edema of face and tongue. *Hematologic:* Bone marrow depression including agranulocytosis; leukopenia; eosinophilia; purpura; thrombocytopenia. *Gastrointestinal:* Nausea; epigastric distress; vomiting; anorexia; stomatitis; peculiar taste; diarrhea; parotid swelling; black tongue. Rarely hepatitis (including altered liver function and jaundice). *Endocrine:* Testicular swelling and gynecomastia in the male; breast enlargement and galactorrhea in the female; increased or decreased libido; elevated or lowered blood sugar levels. *Other:* Dizziness, weakness; fatigue; headache; weight gain or loss; increased perspiration; urinary frequency; mydriasis; drowsiness; alopecia. *Withdrawal Symptoms:* Abrupt cessation after prolonged administration may produce nausea, headache, and malaise. These are not indicative of addiction.

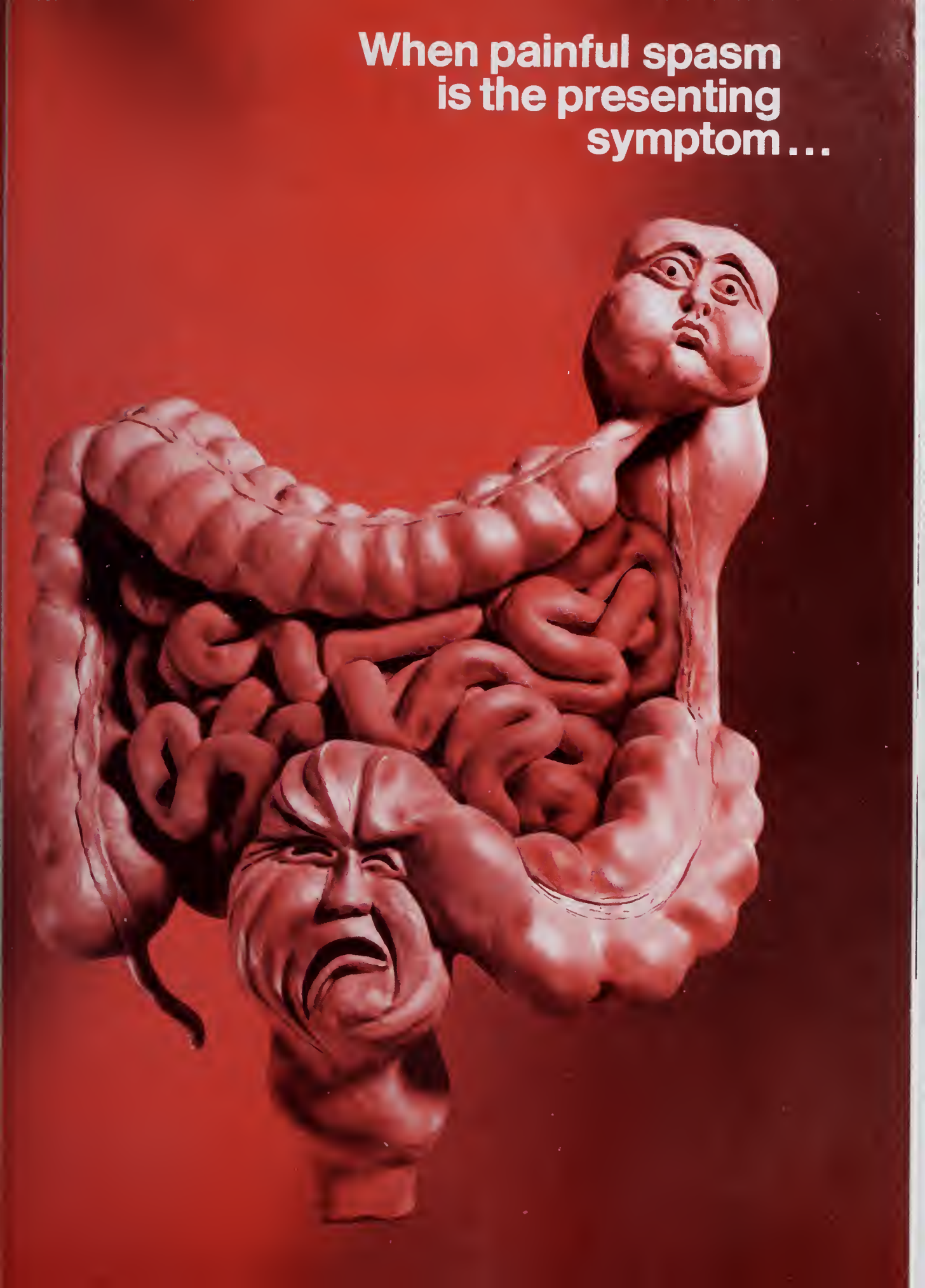
OVERDOSAGE: All patients suspected of having taken an overdosage should be admitted to a hospital as soon as possible. Treatment is symptomatic and supportive. However, the intravenous administration of 1–3 mg of physostigmine salicylate is reported to reverse the symptoms of tricyclic antidepressant poisoning. Because physostigmine is rapidly metabolized, the dosage of physostigmine should be repeated as required particularly if life-threatening signs such as arrhythmias, convulsions, and deep coma recur or persist after the initial dosage of physostigmine. On this basis, in severe overdosage with perphenazine-amitriptyline combinations, symptomatic treatment of central anticholinergic effects with physostigmine salicylate should be considered.

J9TR33 (DC66132

For more detailed information, consult your MSD Representative or see full Prescribing Information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486.

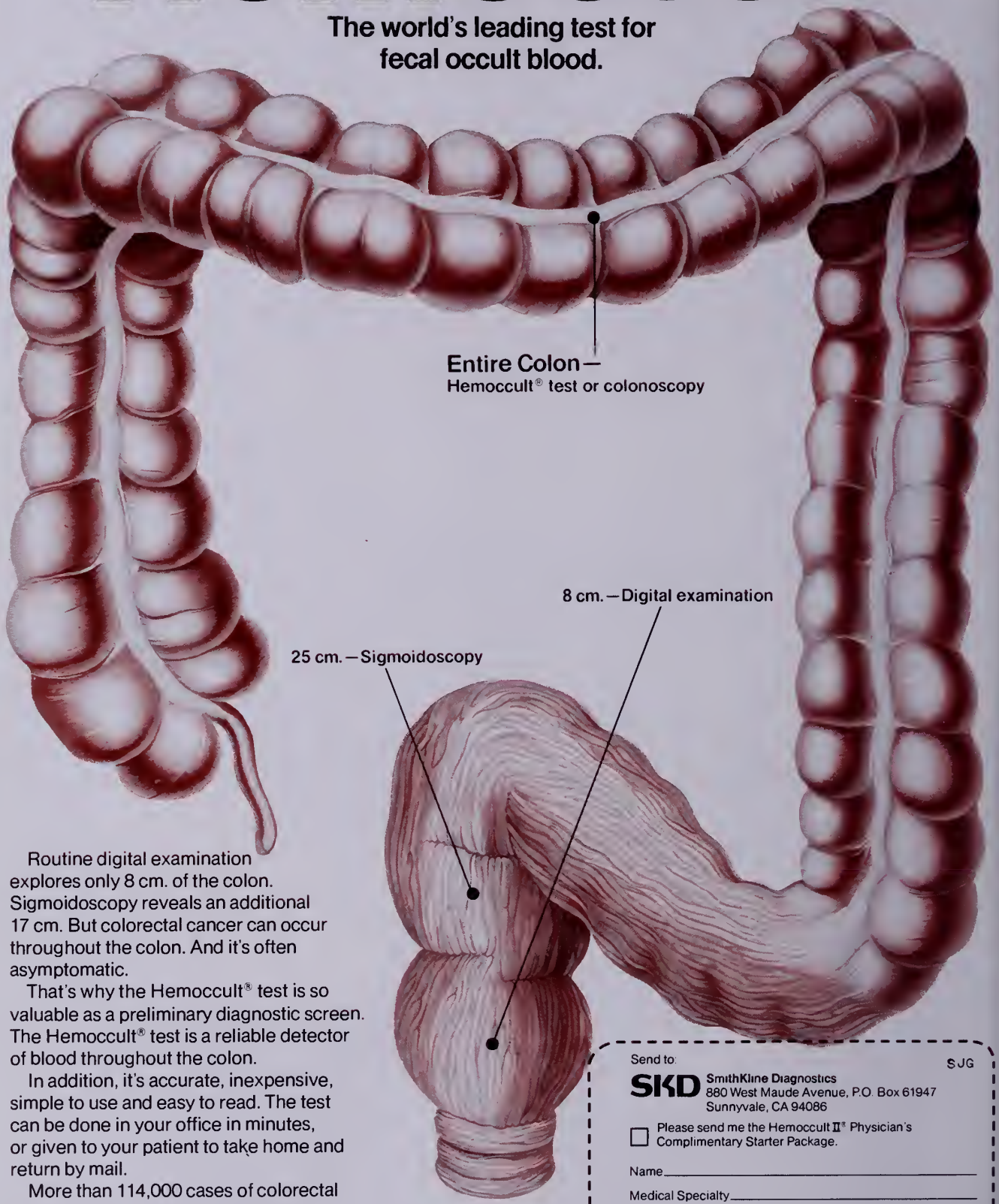
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When painful spasm is the presenting symptom...



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The world's leading test for fecal occult blood.



Routine digital examination explores only 8 cm. of the colon. Sigmoidoscopy reveals an additional 17 cm. But colorectal cancer can occur throughout the colon. And it's often asymptomatic.

That's why the Hemoccult® test is so valuable as a preliminary diagnostic screen. The Hemoccult® test is a reliable detector of blood throughout the colon.

In addition, it's accurate, inexpensive, simple to use and easy to read. The test can be done in your office in minutes, or given to your patient to take home and return by mail.

More than 114,000 cases of colorectal cancer will occur in the United States this year. The earlier they are diagnosed, the greater the chances for successful treatment. Send for your free Hemoccult® starter package, today.

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Sunnyvale, CA 94086

☐ Please send me the Hemoccult II® Physician's Complimentary Starter Package.

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Medical Specialty_____

Address_____

City_____ State_____ Zip_____

Phone_____

Hemoccult® is available through local distributors, nationwide.

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...in the functional bowel/irritable bowel syndrome*

Bentyl®

(dicyclomine hydrochloride USP)

10 mg. capsules, 20 mg. tablets,
10 mg./5 ml. syrup, 10 mg./ml. injection

helps control abnormal motor activity
with minimal anticholinergic side effects†

Demonstrated smooth muscle relaxant activity.

In this double-blind study, twenty patients having G.I. series and exhibiting spasm were randomly selected to receive either 2 cc. of Bentyl or sodium chloride intramuscularly. Ten minutes after the injection another radiograph was taken . . .

. . . Bentyl produced definite relaxation in 8 of 10 patients. The sodium chloride produced relaxation in only 3 of 10. No side effects occurred in either group of patients



Pylorospasm has almost totally blocked passage of barium meal.



Barium meal beginning to pass 10 minutes after intramuscular injection of 20 mg. Bentyl.

"The correlation of spasm relief and drug given was excellent."

*This drug has been classified "probably" effective in treating functional bowel/irritable bowel syndrome.

†See Warnings, Precautions and Adverse Reactions.

See following page for prescribing information.

Reference:
King, J.C. and Starkman, N.M.: Evaluation of an antispasmodic. Double-blind evaluation to control gastrointestinal spasms occurring during radiographic examination. A preliminary report. Western Med. 5:356-358, 1964

Merrell

8-4420 (Y736A) MNR-804

Bentyl®

(dicyclomine hydrochloride USP)

Capsules, Tablets, Syrup, Injection

AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

INDICATIONS

Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the following indications as "probably" effective.

For the treatment of functional bowel/irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS.

For use in the treatment of infant colic (syrup).

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient; unstable cardiovascular status in acute hemorrhage; severe ulcerative colitis; toxic megacolon complicating ulcerative colitis; myasthenia gravis. WARNINGS: In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. PRECAUTIONS: Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy. Use with caution in patients with: Autonomic neuropathy. Hepatic or renal disease. Ulcerative colitis. Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon. Hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension. Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.

Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur. ADVERSE REACTIONS: Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia; urinary hesitancy and retention; blurred vision and tachycardia; palpitations; mydriasis; cycloplegia; increased ocular tension; loss of taste; headache; nervousness; drowsiness; weakness; dizziness; insomnia; nausea; vomiting; impotence; suppression of lactation; constipation; bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation. DOSAGE AND ADMINISTRATION: Dosage must be adjusted to individual patient's needs.

Usual Dosage: Bentyl 10 mg. capsule and syrup: *Adults*: 1 or 2 capsules or teaspoonfuls syrup three or four times daily. *Children*: 1 capsule or teaspoonful syrup three or four times daily. *Infants*: ½ teaspoonful syrup three or four times daily. (May be diluted with equal volume of water.) Bentyl 20 mg.: *Adults*: 1 tablet three or four times daily. Bentyl Injection: *Adults*: 2 ml. (20 mg.) every four to six hours intramuscularly only. NOT FOR INTRAVENOUS USE. MANAGEMENT OF OVERDOSE: The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine® (bethanecol chloride USP) should be used.

Product Information as of October, 1978.

Injectable dosage forms manufactured by CONNAUGHT LABORATORIES, INC., Swiftwater, Pennsylvania 18370 or TAYLOR PHARMACAL COMPANY, Decatur, Illinois 62525 for MERRELL-NATIONAL LABORATORIES, Division of Richardson-Merrell Inc., Cincinnati, Ohio 45215, U.S.A.

Merrell

MERRELL-NATIONAL LABORATORIES
Division of Richardson-Merrell Inc
Cincinnati, Ohio 45215, U.S.A.

UNIVERSITY OF MIAMI SCHOOL OF MEDICINE

MASTER APPROACH TO CARDIOVASCULAR PROBLEMS

Eighth Annual Conference

At

The Contemporary Hotel
Walt Disney World Resort Complex
Orlando, Florida

May 30th - June 1st, 1980

Guest Speakers: J. O'Neal Humphries, M.D., Leo Schamroth, M.D.

University of Miami Faculty: Agustin Castellanos, M.D., Bernard Fogel, M.D., Louis Lemberg, M.D., and Robert J. Myerburg, M.D.

(For more information please call (305) 325-6411 or complete coupon and mail to: Y. Barcena — Cardiology (D-39) University of Miami School of Medicine — P.O. Box 016960 — Miami, FL 33101).

Please send me more information regarding "MASTER APPROACH TO CV PROBLEMS"

Name _____

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_____



Can you have too much of a good thing?

Too much milk, many pediatricians warn, can fill a child up and consequently, can keep him from eating other foods he needs. Particularly, iron-rich foods.

And, of course, that's a major dietary concern.

But you can also have too little of a good thing. Especially, milk. Milk supplies more essential nutrients per calorie than most other foods.

A child between the ages of six months and six years, for example, can get at least three-fourths of his daily dietary allowance for calcium, riboflavin, vitamins D and B_{12}, phosphorus, and protein from just three glasses of milk. And milk is also a good source of vitamins A and B_6, as well as thiamin and niacin.

That's why the U.S.D.A., acting on the recommendation of the National Research Council—National Academy of Sciences, has established these guidelines for milk consumption:

Children up to 6 years
Two to three 8 oz. glasses per day.

Children 6 to 12 years
Three or more 8 oz. glasses per day.

For a free copy of the Dairy Council Digest issue titled, "Composition and Nutrient Value of Dairy Foods," contact your local Dairy Council or write the National Dairy Council, 6300 North River Road, Rosemont, Illinois 60018.

Per cent of Recommended Daily Allowance contributed by three 8 oz. glasses of fortified milk.

	6 mos.—1 yr.	1 yr.—3 yrs.	3 yrs.—6 yrs.
Calcium	100%	100%	100%
Riboflavin	100	100	100
Vitamin B_{12}	100	100	100
Protein	100	100	80
Phosphorus	100	85	85
Vitamin B_6	76	51	34
Vitamin D	75	75	75
Niacin*	71	63	47
Thiamin	56	40	31
Vitamin A	46	46	37

*maximum niacin equivalents based on: 60 mg tryptophan=1 mg niacin

ndc **National Dairy Council**

Milk. Sometimes we forget all the good things it does.



FROM THE EDITOR'S DESK

SECOND OPINIONS

The Federal Government has launched a Madison Avenue-type campaign to encourage Americans to get second opinions before submitting to surgery. The campaign will make use of radio and TV, brochures, posters and a toll-free hot line patients can use to get the names of physicians who are willing to give second opinions. HEW Secretary Patricia Harris believes the campaign will improve the quality of health care and help reduce unnecessary surgery. AMA Executive Vice President James H. Sammons, M.D., said AMA has always encouraged second opinions when a diagnosis is uncertain but to seek such opinions in all cases can only further increase the cost of health care.

CLINICAL TRIAL

The U.S. Food and Drug Administration has given conditional approval to a clinical trial of laetrile on humans. The National Cancer Institute, which is conducting the research, will work with rabbits before a three-month toxicity study on six patients. If the testing demonstrates the substance is safe for human use, NCI will conduct a full clinical trial lasting about a year and involving about 300 volunteer patients with advanced cancer.

ANTITRUST

The State of Ohio has filed an antitrust suit against the Joint Commission on Accreditation of Hospitals (JCAH). The action alleges that JCAH has conspired to suppress psychologists from competing with physicians in rendering psychological care at JCAH hospitals. The complaint stated that Ohio law allows licensed clinical psychologists to practice without physician supervision. Named as co-conspirators were the Ohio State Medical Association, the Ohio Psychiatric Association, and the physician member organizations of JCAH--the American Medical Association, the American College of Physicians and the American College of Surgeons.

DIRECTORY

The Miami-based U.S. Directory Service is again soliciting physicians to "participate" in a medical directory listing with a $20 payment. And once again, the American Medical Association reminds physicians that the Florida operation is not to be confused with the American Medical Directory which is published by AMA and lists all U.S. physicians at no charge.

MEDICAL EDUCATION

AMA's Council on Medical Education has called for restructuring third and fourth-year medical school curricula. In a report to the AMA House of Delegates at its meeting last December, the Council also advocated a "comprehensive residency" for all first-year residents, and establishment of a committee of "public and professional statesmen" to make policy recommendations to the Council.

HOUSE STAFF

The U.S. House of Representatives has rejected a bill that would allow house staff to form labor unions. Several years ago, Congress extended the National Labor Relations Act to private hospitals, but two years later, the National Labor Relations Board ruled that house staff were not subject to the act because these physicians are primarily students, not employees. AMA has recognized and supported the right of house staff to engage in collective bargaining.

STUDENT GRANTS

Thirteen medical students have been designated by the AMA Education and Research Foundation as Rock Sleyster Scholars. Each student, including Orin L. Bigman of the University of Florida College of Medicine, receives a $2,000 grant for the school year. The program honors Rock Sleyster, M.D., President of the AMA in 1939-40.

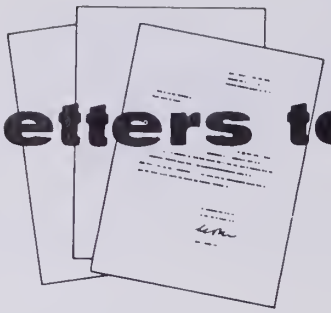
GOOD HEALTH

Improvements in the infant mortality rate and in life expectancy have led Assistant HEW Secretary for Health Julius B. Richmond, M.D., to say: "The Health of the American people has never been better." His assessment is supported by the latest government figures which show the infant mortality rate in 1978 was 13.6 per 1,000 live births, a 3.5% improvement over the previous year. Average life expectancy has increased about three years in the past decade to the present 73.2 years.

NEW PAMPHLET

The AMA Section on Medical Schools has published a pamphlet entitled "AMA's New Voice in the House: The Academician." Among other things, the pamphlet points out that during 1978, AMA proposed 27 draft bills and presented testimony 200 times on regulations and legislation affecting medical education and health care delivery. Copies are available from the Section on Medical Schools, AMA Headquarters.

The Editor



Letters to the Editors

ON CUTTING FEES

(Editor's Note: The following exchange of letters actually happened several months ago and was submitted to *The Journal* by a member of the FMA. Names have been deleted for obvious reasons).

Dear Dr. _____:

This office represents the estate of _____ Please be advised that the undersigned is shocked at the amount of medical charges! I have information which leads me to believe that the services rendered were not punctual or within acceptable medical standards. In addition, much of the treatment may have been rendered at a point of time beyond help.

The children of _____ are willing to pay from their own funds a portion of the debts. Taking into account the great medical costs, funeral expenses and facts of the matter they will compromise your bill at 50%.

Please advise.

Very truly yours,
The Attorney at Law

Dear Attorney:

Your shock didn't approach mine, when I learned of attorney contingency fees. Moreover, I doubt if I could afford to pursue your slanderous statements in that letter, knowing legal fees.

It's sad to give as much as I do to a profession like mine, and the reward is a letter as yours. I would eagerly welcome and enthusiastically observe the chance to see you or any member of that family do what I did for that patient better or cheaper.

Notwithstanding the affront of your letter, I have been sympathetic to bereaved's medical bills in the past and will accept their 50% payment and insurance payment as payment in full.

Who will decide the compromise of your bill? A doctor I hope. It's only just.

Sincerely,
The Doctor

RESPONSIBLE SUPERVISION DEFINED

Paul F. Tumlin, M.D.
710 East Pine Street
Leesburg, Florida

Dear Doctor Tumlin: I have been asked to define for you responsible supervision as it applies to a physician's employment of a Physician's Assistant.

Supervision means responsible supervision and control, with a licensed physician assuming legal liability for the services rendered by the Physician's Assistant. Except in cases of emergency, supervision shall require the easy availability or physical presence of a licensed physician for consultation and direction of the actions of the Physician's Assistant. The responsible and supervising physician must be in a location to enable him to be physically present with the Physician's Assistant within at least thirty minutes and must be available to the Physician's Assistant when needed for consultation and advice, either in person or by communication devices such as telephone, two-way radio, medical beeper or other electronic means. Direct supervision means, of course, with the physician being physically present with the Physician's Assistant. Indirect supervision means that the physician is not actually physically present in the same office or place where the Physician's Assistant is performing. Unavailability of the physician means that he is not available for patient care or consultation by the Physician's Assistant by any means. For example, he is out of town on a trip, signed out to another physician, sick in bed, or unable to practice or be available for any other reason.

If a Physician's Assistant's employing and responsible physician is unavailable then the Physician's Assistant cannot function or he must be under the supervision of another physician designated by the employing physician and known to be available by the Physician's Assistant.

I hope that this answers your question.

Sincerely yours,
George S. Palmer, M.D.
Executive Director



ADMINISTRATOR-FMA
INSURANCE PLANS

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PHONE 354-5910
WATS 1-800-342-8349

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physicians'
INSURANCE
RECIPROCAL

ADMINISTRATOR

The FMA Hospital Money Plan

Money, Money, Money. There's seldom enough to go around when you are healthy. There's never enough when you or a member of your family is hospitalized.

Unexpected expenses, Loss of income. Uncovered costs. Inflation, These, and more, can quickly add up to a severe financial burden that could take years to overcome. Unless . . . you have the foresight to help prevent such an occurrence tomorrow by enrolling in the Hospital Money Plan today.

This supplemental insurance plan — sponsored by your Florida Medical Association — has been developed to help meet the pressing financial demands you'll face when hospitalized.

In essence, the Hospital Money Plan simply provides a valuable daily benefit . . .

- up to $100 per day
- from the first day of confinement
- up to age 65 (after age 64, for one full year)
- in addition to all other insurance you may have

. . . for each and every day you are hospitalized by a covered accident or sickness.

Best of all, you and your eligible family members are *guaranteed acceptance* — regardless of your health histories! There are no questions asked, no physical exams required.

It makes sense to help provide protection for your future . . . and your family's future. For further information concerning the Plan, contact the Professional Insurance Management Company (PIMCO).

Florida Medical Association Auxiliary, Inc.

FOURTEENTH ANNUAL BENEFIT ART SHOW

Exhibit Rules and Regulations

Read Rules Carefully

1. All entries must be original work.
2. Pictures must be framed and wired for hanging. (Stands will be provided for sculpture, etc.)
3. Each entry must have a typed card indicating Name, Address, Medium, Dimensions and Title. Please list price if entry is for sale; otherwise, mark not for sale (NFS).
4. Only one artist's name should be listed for each registration slip.
5. A registration fee of $10 will be charged for each entry. Entry fees are tax deductible.
6. All registration slips and checks must be sent in together no later than April 23, 1980.
7. All pre-registered entries are to be delivered by hand to the Exhibit Hall at the Diplomat Hotel no later than 3:00 p.m. Wednesday, May 7. Shipped entries will be refused.
8. All entries must remain on exhibition until noon Saturday, May 10. They MUST be picked up between noon and 1:00 p.m., Saturday.
9. We will not be responsible for entries not picked up by 1:00 p.m., Saturday, May 10, 1980.
10. Doctors, their wives and children are eligible to enter. Entry fees will be donations to AMA-ERF, divided equally among Florida medical schools.

Kindly enter my registration to show in the Benefit Art Show.

Fee of $ _____ for _____ entries is enclosed. I agree to abide by the rules and regulations for exhibiting material in the show.

Name _____

Address _____

City _____ County _____

I will be showing in the following categories: Please check (X) appropriate category (categories) applying to your entry (entries).

( ) A. Painting. Include any media in color: acrylic, oil, casein, collage, watercolor, pastel, etc.

Size: _____ (H) x _____ (W) To be hung on wall.

( ) B. Graphics. Include a pen and ink, charcoal, photography, etc.

Size: _____ (H) x _____ (W)

( ) C. Crafts. Include sculpture, pottery, ceramics, mosaic, weaving, jewelry, etc.

Size: _____ (L) x _____ (D) x _____ (H)

( ) I am the son/daughter of a Florida physician. Age _____

Judges will give "Awards of Merit" and "Best in Show." An "Editor's Award," given by the Journal of the Florida Medical Association, will be used on the cover of a future issue of the FMA Journal.

A registration fee of $10 will be charged for each entry. Make checks payable to:

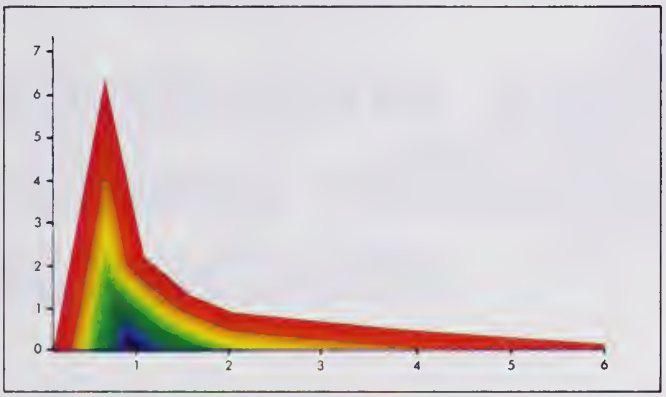
FMA-A Art Show
c/o Mrs. Carlos G. Llanes
11225 S.W. 58th Court
Miami, Florida 33156

NOTE: It is most important to know the size of your art objects, paintings, etc., to enable us to display them more professionally. We will not be responsible for damage or loss of any entry.

REGISTRATION DEADLINE APRIL 23, 1980.

Judging will take place beginning at 9:00 a.m. on Thursday, May 8, 1980.

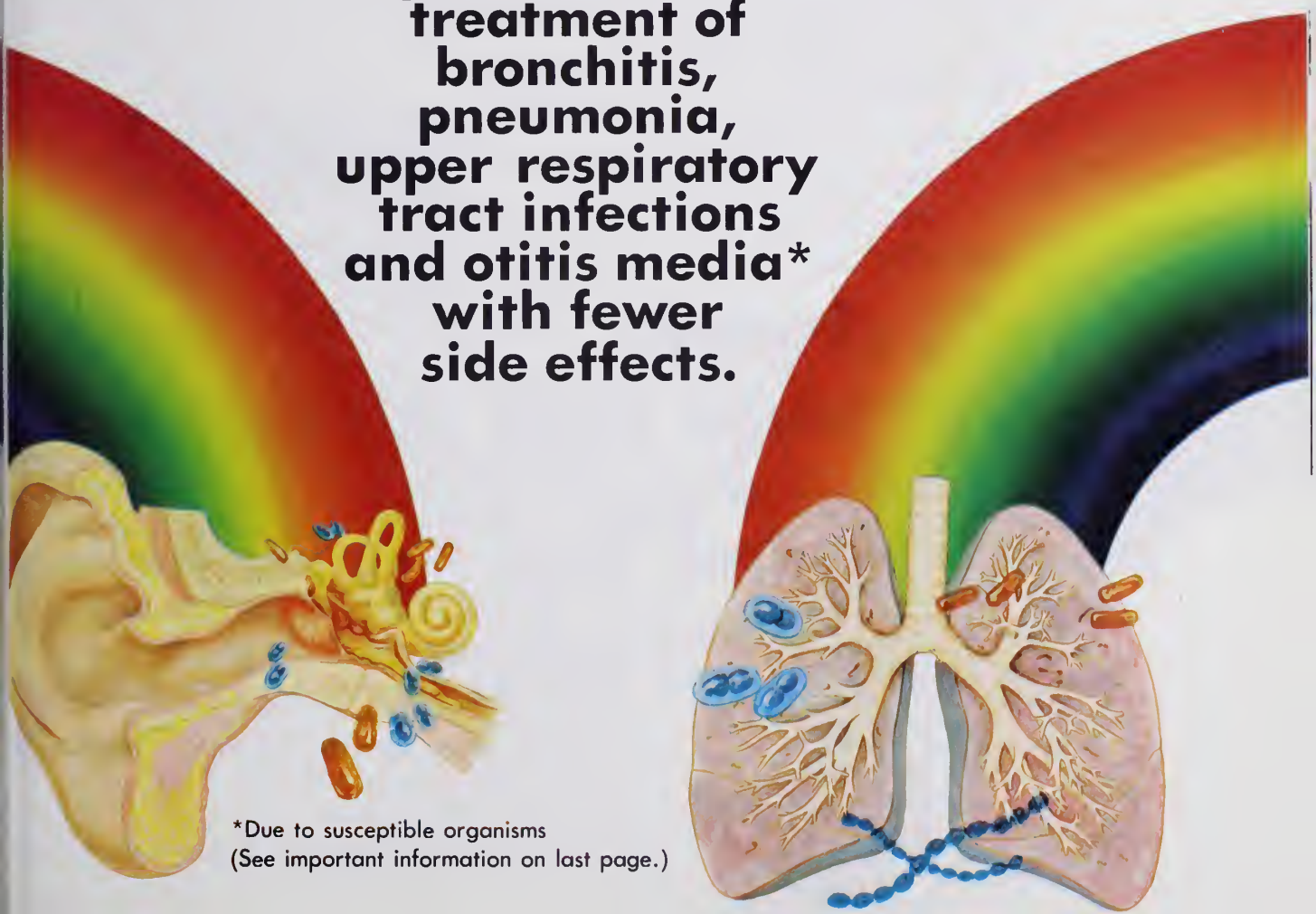
more than just spectrum



New CYCLAPEN®

(cyclacillin) Tablets/ Suspension

Efficacy proven in the treatment of bronchitis, pneumonia, upper respiratory tract infections and otitis media* with fewer side effects.



*Due to susceptible organisms
(See important information on last page.)

New CYCLAPEN®

(cyclacillin) Tablets/ Suspension

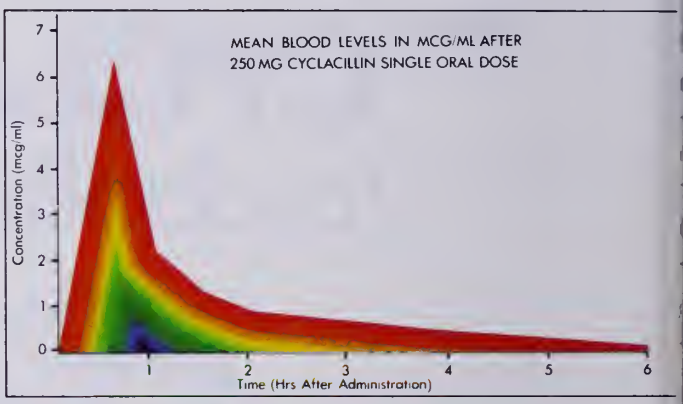
efficacy with fewer side
ampicillin confirmed in
studies of 2,581

Rapid, virtually complete absorption from GI tract

Rapid onset of action—mean peak serum levels within 30 minutes

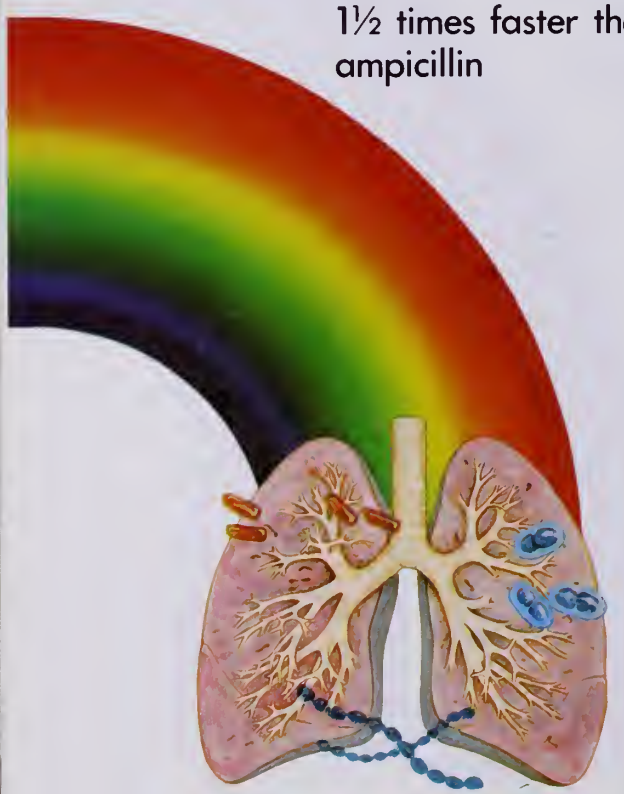
Exceptionally high peak blood levels—3 times greater than ampicillin (clinical efficacy may not always correlate with blood levels)

Rapidly excreted unchanged in the urine—1½ times faster than ampicillin



High cure rate with CYCLAPEN®		
Causative Organism	Bronchitis/Pneumonia†	No. of Patients
S. pneumoniae	100 / 95	73
Chronic Bronchitis† (acute exacerbation)		
H. influenzae	92 — Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H influenzae*	12
Streptococcal Sore Throat†		
Group A beta-hemolytic Streptococcus	100 / 86	44

% Clinical Response
% Bacterial Eradication



more than just spectrum in bronchitis, pneumonia and upper respiratory tract infections†

*Includes all patients treated. 2,415 evaluated for safety; 1,819 evaluated for efficacy.

†Due to susceptible organisms.

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ffects than louble-blind patients*

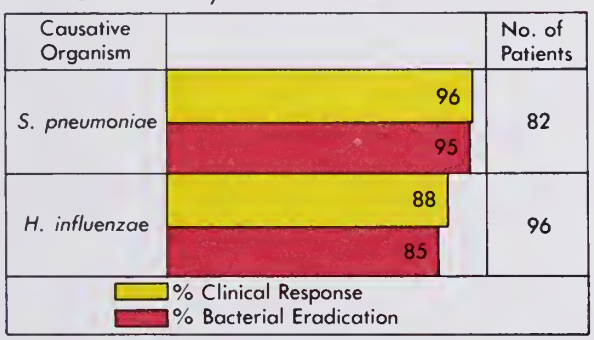


ver side effects with CYCLAPEN® in uble-blind studies to date[1,2]

Total number of drug-related side effects in all patients	
YCLAPEN®	128 of 1,286 (10%) of patients
ampicillin	202 of 1,129 (18%) of patients
Difference statistically significant (P <0.001)	

more than just spectrum in otitis media

Clinical efficacy of CYCLAPEN® in otitis media†



CLAPEN® (cyclacillin)
ective for bronchitis, pneumonia, l upper respiratory tract infections†

- xcellent clinical results in bronchitis, neumonia and upper respiratory tract nfections
- ignificantly lower incidence of diarrhea nd skin rash

ld JA, Hegarty CP, Deitch MW, Walker BR: uble-blind clinical trials of oral cyclacillin d ampicillin, *Antimicrob Ag Chemother* 55-58, (Jan.) 1979.

ta on file, Wyeth Laboratories.

more than just spectrum CYCLAPEN®

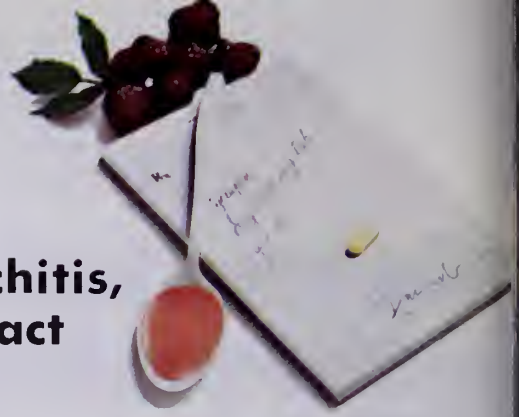
(cyclacillin) Tablets/ Suspension

eth Laboratories
Philadelphia, Pa 19101

important information on next page)

New from Wyeth Laboratories

CYCLAPEN®
(cyclacillin) Tablets/ Suspension



more than just spectrum in bronchitis, pneumonia, upper respiratory tract infections and otitis media*

- Rapid, virtually complete absorption from GI tract
- Rapid onset of action—mean peak serum levels within 30 minutes
- Exceptionally high peak blood levels—3 times greater than ampicillin (clinical efficacy may not always correlate with blood levels)
- Rapidly excreted unchanged in the urine—1½ times faster than ampicillin
- Significantly fewer episodes of diarrhea and skin rash than reported with ampicillin in studies to date
- Excellent clinical response and outstanding bacterial eradication documented in double-blind studies involving 2,581 patients
- New CYCLAPEN® Suspension—great-tasting raspberry punch flavor

*Due to susceptible organisms.

How Supplied

CYCLAPEN® (cyclacillin) tablets:
250 mg scored tablets
500 mg scored tablets

CYCLAPEN® (cyclacillin) for oral suspension
125 mg per 5 ml:
100 ml and 200 ml bottles
250 mg per 5 ml:
100 ml and 200 ml bottles

Indications

Cyclapen® (cyclacillin) has less in vitro activity than other drugs in the ampicillin class of antibiotics and its use should be confined to the indications listed below

Cyclapen® is indicated for the treatment of the following infections

RESPIRATORY TRACT

Tonsillitis and pharyngitis caused by Group A beta-hemolytic streptococci

Bronchitis and pneumonia caused by *S. pneumoniae* (formerly *D. pneumoniae*)

Otitis Media caused by *S. pneumoniae* (formerly *D. pneumoniae*) and *H. influenzae*

Acute exacerbation of chronic bronchitis caused by *H. influenzae**

*Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzae*

SKIN AND SKIN STRUCTURES (integumentary) infections caused by Group A beta-hemolytic streptococci and staphylococci, non-penicillinase producers.

URINARY TRACT INFECTIONS caused by *E. coli* and *P. mirabilis* (This drug should not be used in any infections caused by *E. coli* and *P. mirabilis* other than urinary tract infections.)

NOTE: Cultures and susceptibility tests should be performed initially and during treatment to monitor the effectiveness of therapy and the susceptibility of bacteria. Therapy may be instituted prior to the results of sensitivity testing.

Contraindications

The use of this drug is contraindicated in individuals with a history of an allergic reaction to penicillins.

Warnings

CYCLACILLIN SHOULD ONLY BE PRESCRIBED FOR THE INDICATIONS LISTED IN THIS INSERT.

CYCLACILLIN HAS LESS *IN VITRO* ACTIVITY THAN OTHER DRUGS OF THE AMPICILLIN CLASS ANTIBIOTICS. HOWEVER, CLINICAL TRIALS HAVE DEMONSTRATED THAT IT IS EFFICACIOUS FOR THE RECOMMENDED INDICATIONS.

SERIOUS AND OCCASIONAL FATAL HYPERSENSITIVITY (ANAPHYLACTOID) REACTIONS HAVE BEEN REPORTED IN PATIENTS RECEIVING PENICILLIN.

ALTHOUGH ANAPHYLAXIS IS MORE FREQUENT FOLLOWING PARENTERAL ADMINISTRATION, IT HAS OCCURRED IN PATIENTS ON ORAL PENICILLINS. THESE REACTIONS ARE MORE APT TO OCCUR IN INDIVIDUALS WITH A HISTORY OF SENSITIVITY TO MULTIPLE ALLERGENS. THERE ARE REPORTS OF PATIENTS WITH A HISTORY OF PENICILLIN HYPERSENSITIVITY REACTIONS WHO EXPERIENCED SEVERE HYPERSENSITIVITY REACTIONS WHEN TREATED WITH A CEPHALOSPORIN BEFORE THERAPY WITH A PENICILLIN. CAREFUL INQUIRY SHOULD BE MADE ABOUT PREVIOUS HYPERSENSITIVITY REACTIONS TO PENICILLINS, CEPHALOSPORINS, AND OTHER ALLERGENS. IF AN ALLERGIC REACTION OCCURS, THE DRUG SHOULD BE DISCONTINUED AND APPROPRIATE THERAPY SHOULD BE INITIATED. SERIOUS ANAPHYLACTOID REACTIONS REQUIRE IMMEDIATE EMERGENCY TREATMENT WITH EPINEPHRINE. OXYGEN, INTRAVENOUS STEROIDS, AIRWAY MANAGEMENT, INCLUDING INTUBATION, SHOULD ALSO BE ADMINISTERED AS INDICATED.

Precautions

Prolonged use of antibiotics may promote the overgrowth of nonsusceptible organisms. If superinfection occurs during therapy, appropriate measures should be taken.

PREGNANCY: Pregnancy Category B. Reproduction studies have been performed in mice and rats at doses up to ten times the human dose and have revealed no evidence of impaired fertility or harm to the fetus due to cyclacillin. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

NURSING MOTHERS: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when cyclacillin is administered to a nursing woman.

Adverse Reactions

The oral administration of cyclacillin is generally well tolerated.

As with other penicillins, untoward reactions of the sensitivity phenomena are likely to occur, particularly in individuals who have previously demonstrated hypersensitivity to penicillins or in those with a history of allergy, asthma, fever, or urticaria.

The following adverse reactions have been reported with the use of cyclacillin: diarrhea (in approximately 1 out of 20 patients treated), nausea and vomiting (in approximately 1 in 50), and skin rash (in approximately 1 in 60). Isolated instances of headache, dizziness, abdominal pain, vaginitis, and urticaria have been reported. (See WARNINGS)

Other less frequent adverse reactions which may occur and that have been reported during therapy with other penicillins are: anemia, thrombocytopenia, thrombocytopenic purpura, leukopenia, neutropenia and eosinophilia. These reactions are usually reversible on discontinuation of therapy.

As with other semisynthetic penicillins, SGOT elevations have been reported.

Dosage and Administration

INFECTION*	ADULTS	CHILDREN
		Dosage should not exceed that in a dose higher than for adults
Respiratory Tract		
Tonsillitis & Pharyngitis**	250 mg q.i.d. in equally spaced doses	body weight <20 lbs) 125 mg q.i.d. equally spaced doses body weight >20 lbs) 250 mg q.i.d. equally spaced doses
Bronchitis and Pneumonia		
Mild or Moderate Infections	250 mg q.i.d. in equally spaced doses	50 mg/kg/day q.i.d. equally spaced doses
Chronic Infections	500 mg q.i.d. in equally spaced doses	100 mg/kg/day q.i.d. equally spaced doses
Otitis Media	250 mg to 500 mg q.i.d. in equally spaced doses depending on severity	50 to 100 mg/kg/day q.i.d. equally spaced doses depending on severity
Skin & Skin Structures	250 mg to 500 mg q.i.d. in equally spaced doses depending on severity	50 to 100 mg/kg/day q.i.d. equally spaced doses depending on severity
Urinary Tract	500 mg q.i.d. in equally spaced doses	100 mg/kg/day in equally spaced doses.

*As with antibiotic therapy generally, treatment should be continued for a minimum of 48 to 72 hours after the patient becomes asymptomatic or evidence of bacterial eradication has been obtained.

**In infections caused by Group A beta-hemolytic streptococci, a minimum of 10 days of treatment is recommended to guard against the risk of rheumatic fever or glomerulonephritis.

In the treatment of chronic urinary tract infection, frequent bacteriologic and clinical appraisal is necessary during therapy and may be required for several months afterwards.

Persistent infection may require treatment for several weeks.

Cyclacillin is not indicated in children under 2 months of age.

Patients with Renal Failure

Based on a dosage of 500 mg q.i.d., the following adjustment in dosage interval is recommended.

Patients with a creatinine clearance of >50 ml/min need no dosage interval adjustment.

Patients with a creatinine clearance of 30-50 ml/min should receive full doses every 12 hours.

Patients with a creatinine clearance of between 15-30 ml/min should receive full doses every 18 hours.

Patients with a creatinine clearance of between 10-15 ml/min should receive full doses every 24 hours.

In patients with a creatinine clearance of <10 ml/min or serum creatinine values of ≥ 10 mg %, serum cyclacillin levels are recommended to determine both subsequent dosage and frequency.

Wyeth Laboratories
Philadelphia, Pa. 19101

NEW
PRODUCT
INFORMATION

clinical significance



of constipation

WILLIAM H. RORER, INC.
Fort Washington, PA 19034

Constipation acute or chronic

Constipation may be caused by conditions affecting the filling and emptying of the rectum.

Inadequate filling

Interference in propulsive contractions

Impairment of smooth muscle contractility

Obstruction of the lumen





Inadequate emptying

Interference in the stimulation of the defecation reflex

An additional complication

Self treatment—use and abuse of laxatives

Treatment of underlying disorders is critical... Relief of constipation is essential

Perdiem™...distinctive!

A unique blend of natural vegetable derivatives For comfortable and safe relief of constipation

Psyllium

- A natural source of hydraphillic callaids
- Strengthens stimulus to defecate by increasing indigestible residue
- Helps produce soft, hydrated, well formed stool



Senna

- Produces mild peristaltic stimulation
- Helps propel bulk through colon



A unique granular formulation

- No mixing or chewing
- Granules are placed in mouth and swallowed with full glass of beverage
- Helps break cathartic habituation
- Helps establish normal defecatory reflexes and regular bowel rhythm

John Maerz, M.D.
Medical Director
W. H. Rorer, Inc.
Fort Washington, PA 19034

Dear Dr. Maerz:

Yes, I would like to receive a supply of Perdiem™ starter samples for my patients.

Dr. _____

Address _____

City _____

State _____

Zip _____

Specialty _____

SJ-312

New Perdiem™

Prescribing Information

ACTIONS: Perdiem™, with its gentle action, does not produce disagreeable side effects. The vegetable mucilages of Perdiem™ soften the stool and provide pain-free evacuation of the bowel. Perdiem™ is effective as an aid to elimination for the hemorrhoid or fissure patient prior to and following surgery.

COMPOSITION: Natural vegetable derivatives: A unique blend of psyllium and senna (Plantago Hydrocolloid with Cassia Pod Concentrate).

INDICATION: For relief of constipation.

PATIENT WARNING: Should not be used in the presence of undiagnosed abdominal pain. Frequent or prolonged use without the direction of a physician is not recommended. Such use may lead to laxative dependence.

DIRECTIONS FOR USE—ADULTS: Before breakfast and after the evening meal, one to two rounded teaspoonfuls of Perdiem™ granules should be placed in the mouth and swallowed with a full glass of warm or cold beverage. Perdiem™ granules should not be chewed. After Perdiem™ takes effect (usually after 24 hours, but possibly not before 36-48 hours): reduce the morning and evening doses to one rounded teaspoonful. Subsequent doses should be adjusted after adequate laxation is obtained.

IN OBSTINATE CASES: Perdiem™ may be taken more frequently, up to two rounded teaspoonfuls every six hours.

FOR PATIENTS HABITUATED TO STRONG PURGATIVES: Two rounded teaspoonfuls of Perdiem™ in the morning and evening may be required along with half the usual dose of the purgative being used. The purgative should be discontinued as soon as possible and the dosage of Perdiem™ granules reduced when and if bowel tone shows lessened laxative dependence.

FOR COLOSTOMY PATIENTS: To ensure formed stools, give one to two rounded teaspoonfuls of Perdiem™ in the evening with warm liquid.

DURING PREGNANCY: Give one to two rounded teaspoonfuls each evening.

FOR CLINICAL REGULATION: For patients confined to bed, for those of inactive habits, and in the presence of cardiovascular disease where straining must be avoided, one rounded teaspoonful of Perdiem™ taken once or twice daily will provide regular bowel habits. Take with a full glass of water or beverage.

FOR CHILDREN: From age 7—11 years, give one rounded teaspoonful one to two times daily. From age 12 and older, give adult dosage.

NOTE: It is extremely important that Perdiem™ should be taken with a plentiful supply of liquid.

HOW SUPPLIED: Granules; 100 gram (3.5 oz.) and 250 gram (8.8 oz.) canisters.



Made in West Germany

NO POSTAGE NECESSARY IF MAILED IN THE UNITED STATES

BUSINESS REPLY MAIL
FIRST CLASS PERMIT NO. 29 Ft. Washington, PA.

POSTAGE WILL BE PAID BY ADDRESSEE

William H. Rorer, Inc.
500 Virginia Drive
Ft. Washington, PA. 19034

Attn: Marketing Services

ROER

WILLIAM H. RORER, IN
Fort Washington, PA 19034

The primary beneficiaries of ORAL HYDERGINE® TABLETS, 1 mg (1 tab t.i.d.)

Each 1 mg Hydergine tablet contains dihydroergocornine mesylate 0.333 mg, dihydroergocristine mesylate 0.333 mg, and dihydroergocryptine (dihydro-alpha-ergocryptine and dihydro-beta-ergocryptine in the proportion of 2:1) mesylate 0.333 mg, representing a total of 1 mg.

They're in their late sixties, the beneficiaries of more liberal retirement laws and more enlightened attitudes toward the elderly. They're leading socially productive lives. But recently, without any clear cause, they had each begun to experience mild episodes of symptoms such as confusion, mood-depression, and dizziness. Their ability to function could have been jeopardized. That's when they became the beneficiaries of oral Hydergine therapy.



The still-functioning geriatric can benefit from Hydergine treatment

It is quite common for cognitive and emotional symptoms of deterioration to manifest gradually in the elderly. During this early stage, such symptoms are mild and more amenable to treatment. It is at this stage that Hydergine therapy has proved most effective. Patients tend to respond better, and with symptoms effectively relieved—or at least their progression retarded—the ability to function can be maintained.

Oral Hydergine tablets promote better patient compliance

Compared with the sublingual form, dosage administration is easier, with less need for supervision.

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Contraindications: Hypersensitivity to the drug.
Precautions: *Because the target symptoms are of unknown etiology, careful diagnosis should be attempted before prescribing Hydergine tablets and sublingual tablets.*
Adverse Reactions: Serious side effects have not been found. Some sublingual irritation, transient nausea, and gastric disturbances have been reported. Hydergine tablets and sublingual tablets do not possess the vasoconstrictor properties of natural ergot alkaloids.
Dosage and Administration: 1 mg three times daily. Alleviation of symptoms is usually gradual and results may not be observed for 3–4 weeks.
How Supplied: Hydergine tablets (for oral use) 1 mg, packages of 100 and 500. **Hydergine sublingual tablets 1 mg,** containing dihydroergocornine mesylate 0.333 mg, dihydroergocristine mesylate 0.333 mg, and dihydroergocryptine (dihydro-alpha-ergocryptine and dihydro-beta-ergocryptine in the proportion of 2:1) mesylate 0.333 mg, representing a total of 1 mg; packages of 100, 500, and 1000. **Hydergine sublingual tablets 0.5 mg,** containing dihydroergocornine mesylate 0.167 mg, dihydroergocristine mesylate 0.167 mg, and dihydroergocryptine (dihydro-alpha-ergocryptine and dihydro-beta-ergocryptine in the proportion of 2:1) mesylate 0.167 mg, representing a total of 0.5 mg; packages of 100 and 1000.
Before prescribing, see package insert for full product information.

SANDOZ PHARMACEUTICALS, EAST HANOVER, N.J. 07936

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A nation's health is now in your hands.

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THE JOURNAL
OF THE FLORIDA MEDICAL ASSOCIATION INC
MARCH 1980
VOL 67 • NO. 3

Special Issue

University of Florida College of Medicine

Guest Editor
J. Lee Dockery, M.D.

Introduction



Dr. Dockery

On June 6, 1960, the University of Florida College of Medicine graduated its first class of 40 students. On May 31, 1980, the twentieth class will graduate, bringing the total to 1,409 of physicians to receive their M.D. degree here since the College of Medicine's beginning. The man behind the founding dream and who remained for 10 years as the first Dean was Dr. George T. Harrell Jr. As you, the graduates and alumni, gather to honor Dr. Harrell and pay tribute to the many accomplishments of the College of Medicine over the past 20 years, I know you will be pleased with your heritage.

The University of Florida College of Medicine is grateful to the Florida Medical Association for the opportunity to present this special issue of ***The Journal of the Florida Medical Association, Inc.,*** *commemorating the Twentieth Anniversary of the College of Medicine.*

The articles printed in this issue have been prepared to highlight some of the guiding philosophy, the accomplishments, and where the College is today in its continuing effort to fulfill its mission of education, research and service—and yes, even some nostalgia, too.

The Guest Editor would like to express his appreciation to the contributing authors, the editorial staff of ***The Journal of the Florida Medical Association, Inc.,*** *and the Office of Learning Resources and Health Center Communications of the University of Florida College of Medicine for their assistance and support.*

Dr. Dockery is Associate Dean for the University of Florida College of Medicine, Gainesville, Florida.

Founding Dean



George T. Harrell Jr., M.D.
Dean, University of Florida
College of Medicine
1954-1964

The First Years of the University of Florida College of Medicine

George T. Harrell Jr., M.D.

BACKGROUND: The need in Florida for physicians trained for its specific problems was foreseen by the Florida Medical Association. Its program in continuing education had run for some years in conjunction with the Graduate School of the University of Florida. Florida had no medical school and in 1945 the legislature authorized its establishment. President J. Hillis Miller recognized the opportunity in establishing a new school to involve the University generally to a greater extent. He obtained from the Commonwealth Fund a grant for the faculty to study, with the help of consultants from other universities, the type of school which might be established. The results were published in 1953, the same year the legislature appropriated $5 million to construct colleges of medicine and nursing. President Miller asked me in November to become the first dean in January 1954, but unexpectedly died in the interim. Dr. John Allen was appointed Acting President and indicated he was not a candidate for the permanent post.

START: Decisions had to be made quickly in view of the uncertain administrative situation and a pressing time schedule. It was decided to attempt unconventional things in a conventional framework. The program would look at the University study of human biology in all its facets and focus first on the College of Medicine as the key unit in a broad health center. The authorized College of Nursing would be established next, with dentistry to follow when medicine was firmly established. No College of Veterinary Medicine was envisioned at that time. The first departure from tradition would be to incorporate the existing Center for Clinical Services into a new educational unit which would train a wide variety of health personnel who would work at the clinical level with physicians and nurses. The name College of Health Related Professions was adopted.

A national need was recognized for broadly trained physicians who would be family doctors. In Florida, the need was especially acute in small towns and rural areas. A University Health Center also would teach specialists and train all members of future community health care teams to work together. Research, which is an integral part of medical education and is a stimulating educational tool for students and faculty, had to be provided from the beginning.

The most important job in organizing a new school is the selection of faculty. Since a library is the central educational focal point for all students in a broad health center, the first appointment was the librarian. Chairmen of the basic medical science departments were sought next, followed by the clinical ones. Candidates should be young, have demonstrated interest and ability in teaching, be willing to try new educational approaches and cross disciplinary lines, and have demonstrated unusual potential in research. It was felt older, nationally known people would duplicate existing programs, which they knew to work, and be reluctant to try new things. Nominations were solicited of faculty members ranking third or lower in their department, so that the reputations would be made in Gainesville and their names be associated with Florida. From curriculum vitae, the most promising candidates were interviewed, in their own laboratories where students and co-workers could be talked to informally. The best candidates and wives were then brought to campus. The faculty brilliantly fulfilled expectations and was the youngest overall of any medical school at the time. Three of the department heads were only 33 years old.

FACILITIES: Almost nothing had been published on design of medical schools. The architect in the office of the president and the future dean together visited a number of new and old schools. The medical sciences building was to be flexible in design so that changes could be made as programs developed. Inter-disciplinary cooperation was encouraged by placing basic science and clinical departments on the same floors so that joint research and correlated teaching might develop. Small group teaching was to be emphasized. It was decided to build teaching laboratories which could be used interchangeably by several departments, based on the functional principle of stand-up and sit-down student

Dean Emeritus, College of Medicine, University of Florida, Gainesville.

work spaces. A unique design of a faculty research laboratory unit on a modular basis was used. Faculty were told it would suit no one precisely, but if unsatisfactory after three years would be remodeled. A defect in design was the gross underestimation of the mechanical and utility provisions required.

The greatest innovation was the recognition of the need for a home base for all students to serve as the focal point for self-study and learning and to establish patterns which could be followed lifelong in practice. The study cubicles were the first built any where. The pattern was for the student to go to library, laboratory, patient or faculty office, to collect whatever information was needed without undue emphasis on anyone. The synthesis of data, drawing of conclusions and planning a course of action would be done in the study cubicles. The decision not to place this function in the teaching laboratory has been justified by experiences of other schools which did and found students used them little for study.

The need for information on facilities, in view of the expected expansion in the number of new schools, led USPHS (the United States Public Health Service) to publish a book based largely on the Florida design. The book was soon expanded to include hospitals. The Dean chaired the committees for both. The Journal of Medical Education published articles on individual elements of the Gainesville plant with the educational thinking behind each. A large number of visitors from this country and abroad came as a result.

The planning always had included a teaching hospital, but no appropriation had been made before recruitment of clinical faculty had to begin. No patient care plant had been built which was planned from the ground up primarily as a teaching unit. The causes of death and patterns of disease were changing which should place more emphasis on the ambulant patient. The school and its teaching hospital were to serve the state as a whole and not to become a service facility for Alachua County. Patients would be referred by their home physicians and would mainly require specialty care. Both the county and state medical societies feared that the faculty might replace local physicians to the detriment of their established practices. Experience repeatedly had shown that a medical school greatly increased the quality of and demands for medical care and that the number and practices of community physicians steadily grew. The unjustified fear delayed for years a program in primary care.

The hospital and clinics were designed so that bed and ambulatory patients both had equal access to all resources. The first ambulatory beds in a teaching hospital were built with the expectation that they would be the first type expanded. It took years for faculty and third party payers completely to accept the concept. The first ambulant surgery anywhere was built. It is now an accepted practice. The outpatient clinic was designed so that individual examining rooms emphasized the setting found in local communities and involved both the patient and a member of the family. The Outpatient Department (OPD) was placed so that it could expand without the addition of beds and that future dental facilities could be incorporated in overall care. Each inpatient floor had an identical teaching unit which could be used for both medical, nursing and allied health students and for house staff. Elements of the home were built as a small apartment to be used for instruction of patients and family in long term care after discharge. The new concept never was fully implemented, partly because the architectual scale was too small.

The use of radiologic techniques rapidly was increasing and requiring much space for even more sophisticated equipment. The facilities were placed over the OPD so that they could expand simultaneously with growth of the ambulant program. That use of clinical laboratories also would grow was recognized, but the space required for future equipment was greatly underestimated and no provision was made for continual expansion as in radiology.

The general education and science courses for nursing and health related services were to be taught on the main campus. Administrative space for nursing was placed in the hospital where clinical teaching would be done. The lecture rooms in the medical sciences building had been built for classes of 64, but they proved to be undersized. Space for graduate students in the basic medical sciences had been planned for from the beginning. An apartment unit was built adjacent to the hospital primarily for medical students and house officers, but graduate students in all health related fields and social sciences also were placed there to provide a wider interdisciplinary atmosphere. A primary home care program for young families in graduate housing units on campus was considered but never approved.

GROWTH: It was national policy to establish new VA hospitals only in conjuction with medical schools. The one at Lake City was used, chiefly for resident training in surgery and its specialties, but the distant location made it inconvenient for medical student instruction. Eventually, discussions with congressional and VA representatives agreed a new hospital would be integrated completely in the now established teaching program and would be "architectually compatible" with the existing plant. The faculty spent a year preparing a detailed description of space needs for teaching, patient care and clinical research. However, the acreage originally recommended for the VA was not allocated. The present site was agreed upon across a railroad and highway.

Every effort was made to select instruments for the health center buildings which would place research capability at the forefront of progress. A conflict arose over whether sophisticated and expensive equipment should be centrally located or dispersed. The University already was advanced in computer technology and committed to large central units. It was several years before the need for multiple small units in the health center was accepted and made possible by technological progress. Electron microscopy increasingly was being used in biologic teaching and research. The single instrument on campus was in the College of Engineering and was available as a service instrument. However, the medical faculty had needs of their own, were capable of operating these machines and could finance them. Equipment for use of radioactive isotopes also was centered in the College of Engineering which was expert in its design and construction. Soon, the College of Medicine was the largest user on campus and it became apparent that counting equipment was imperative in individual medical school laboratories. The responsibility for campus wide radiation health physics monitoring ultimately was placed in the health center with a degree level training program.

The faculty was successful in competing nationally for increasing federal research grant funds. The central animal facility soon was inadequate in type and location to house all studies, such as those now requiring domestic animals, deer, primates and numbers of dogs, especially for long term research over years. A farm type facility was the obvious answer, which ideally should be on campus and within walking distance to faculty and students. A site with these requirements was impossible to obtain. Eventually six acres of agriculture land were made available, but nearly half was swamp and unusable. The simple and inexpensive design attracted national attention. The usefulness as a resource to attract distinguished senior faculty led to expansion of buildings and land within 10 years.

The need for research capability utilizing primates made the long established Yerkes Laboratory at Orange Park an obvious choice for expansion into one of the first national laboratories. Discussions were held with USPHS for the University to assume responsibility, with the idea of moving to Gainesville in a new physical facility. Political pressure was exerted to keep it in Orange Park which was not convenient for daily use. It was a disappointment when the decision was made to move it to Atlanta where the proven advantage of outdoor year-round cages could not be duplicated.

The medical school soon was the greatest user of marine forms on campus. The small existing unit southwest of Gainesville on Lighthouse Key was accessible only by small boat. Research teams were going to Maine and lobsters were being flown in for experiments. Sea water was brought by truck from the Gulf. USPHS noticed, and a site visit by senior staff was arranged. A brief survey showed the Cedar Key area to have within 12 miles of the dock deep seawater, mud flats, two tidal rivers and fresh black water lakes. A laboratory accessible by car could be used outdoors all year round. Foreign visitors taken there on social occasions indicated it would be internationally used. It was a disappointment that grant funds, which by law would have to be awarded to the medical school, could not be accepted. The laboratory was established later at Marineland.

PROGRAM: To achieve the educational objectives the key basic medical science faculty were brought in early so that they might teach in undergraduate courses. The quality of medical school faculty and the standards for the professional and graduate programs could be demonstrated. The Professor of Medicine was brought in two years early to spend his time in the liberal arts and general education areas.

When the first medical school class entered, the PK Yonge laboratory school was used to show the range of normal growth and development in children physically and intellectually. The Sunland Training Center was used for abnormal examples of mental capacity. To promote the concept of biologic variability, the use of the scientific method in problem solving and the necessity for self-study, a program of student projects was introduced. It was controversial from the beginning, but always when put to faculty vote was continued. Many projects were published.

Administrative difficulties arose over the placement of some disciplines in the University. It became apparent that more emphasis should be placed in the medical curriculum on behavior. The request to add behavioral scientists to the medical faculty was denied on the ground that behavior was a liberal arts—social science field. Eventually, a faculty member with the skills and an MD degree was added to the Department of Psychiatry though the emphasis desired educationally was on the range of normal behavior as it affected all illnesses and clinical specialties.

With the control of infectious diseases, the increase in chronic illnesses, and the functional overlay to organic disease, it became apparent that the life style of individuals was extremely important. How people lead their lives is determined by individual beliefs which are the field of the humanities. It was proposed to add a faculty member in religion as a resource to medical students and teachers. Though a grant to cover cost was offered, the request was denied. The school was told it must use existing University professors. It was tried in

philosophy, but did not work. It was apparent that graduate faculty in any discipline are chiefly concerned with it and replicating themselves. The medical student is concerned with applying any discipline or tool to the solution of the patient problem at hand. It took several years to add a humanist to the health center staff as hospital chaplain. The teaching of humanities as an intregal part of the medical curriculum now has been widely accepted.

The practical clinical teaching of family medicine on campus was not permitted. The objective partially was reached by recruiting general practitioners, chiefly in rural areas, to serve as preceptors, and sending the students to live with them. The need for a rural health center staffed by faculty was not apparent in the early years.

Basic science—clinical correlation never was achieved to the extent hoped, but the successful program in clinical pharmacology started at Florida has been copied by other schools. The multidisciplinary approach in the general clinic was successful in the early years. The chairmen of major clinical departments, such as surgery, psychiatry and obstetrics, took regular turns seeing any patient in rotation as the primary physician and not only in their specialty field. Eventually, the program became a general medical clinic when a separate general pediatric one was established and specialty clinics sprang up with their residencies.

STUDENTS: Pre-medical college advisors were brought on campus to see the facilities and meet faculty. Orientation talks were given emphasizing in successive years the role of the various sciences and other courses in relation to medical teaching. Patterns of study rather than accumulation of facts and techniques were stressed. Diversified students in large numbers applied and those with good records and superior recommendations from teachers were brought on campus for faculty interviews which helped the prospective student plan future courses and activities better to round out his background. Wives or fiancees were invited to come and were interviewed separately. The students enrolled were enthusiastic and attrition rates were low. Most in practice have remained in Florida and many are in family practice.

One program which had considerable impact on students was the overseas experience as an elective after the third year. Students spent up to three months in developing countries, not in major cities, medical schools, or teaching hospitals, but in isolated mission type clinics with a few beds. The objective was to see health care problems in different cultures, the crushing impact of poverty, and diseases now under control in this country. The cultural shock was considerable and many career goals changed. Students learned they could work using only their head and hands without the extensive equipment of a university hospital.

FACULTY: Many of the faculty quickly attained international prominence. Research blossomed, grant funds came and faculty served on various health agency advisory committees. Early turnover was the smallest of any of the new schools, but after 10 years faculty were recruited to head research units, experimental educational programs, into administrative positions as vice-president of a health center, acting president of a major university, and president of a liberal arts college.

ADMINISTRATION: The health center concept on a university campus has proved viable. The medical school is the key unit and experience has shown the advisability of having the chief administrative officer with an M.D. degree who can serve simultaneously as Dean. President Miller made an inspired move when he appointed a medical advisory committee to him, not the Dean, and recruited past presidents of the FMA as members. This device permitted the Dean to try out ideas, get reactions and use the committee as a sounding board for policies which might provoke misunderstanding or controversy. Their backing was essential in the development of the Academic Enrichment Fund program for the clinical practice of faculty. This program was crucial for compensation to reach levels unobtainable by state appropriations alone, but essential to recruit and retain good faculty. The program also has furnished funds for research equipment, matching funds for construction grants, special travel for academic purposes, and other uses, all expended within University rules.

The State Health Department was supportive in many ways. The Dean talked to every Florida county medical society and to innumerable luncheon and service clubs. A small set of blocks to illustrate the stages of construction and future possibilities for growth drew amused comment, but was remembered.

CRITIQUE: After nearly 11 years, the school unquestionably was on a sound path. In November 1964 the Dean moved to build a second new medical school with the magnificent gift of $50 million by the Hershey trust. It was possible at the beginning to implement parts of the program not possible in the early years at Florida, but the lessons learned at Gainesville have been successfully applied and improved.

Reflecting as Dean going through the early years, the enthusiasm of faculty, students and staff all working together and having fun was thrilling. The immediate statewide acceptance by the profession and public of innovative teaching and patient care was stimulating. The national recognition of facilities and research reinforced momentum to continued growth. The acceptance of the medical school as an integral part of the University achieved the original academic objective.

• Dr. Harrell, 2010 Eastridge Road, Timonium, Maryland 21093.

Room M-112: Medical Sciences Building

Jean Lester Bennett, M.D.

In the Fall of 1956—from New York, Massachusetts, West Virginia, Dominican Republic, Florida and even Woodbine, Georgia, a group of 40 medical students gathered who were to become, "blood-brothers," for the next four years and who would carry the prestigious and ominous burden of being the first class to graduate from the University of Florida College of Medicine.

The students had been interviewed in quanset huts, under shade trees, in the halls and yes, even in conference rooms. College grades, MCAT's, letters of reference had been carefully reviewed by the skeleton staff of the school. Suggestions had been made that we needed to spend the last semester of our college years broadening our horizons and understanding the arts, in order to identify with the greater world that stood somewhere outside the walls of the chemistry and biology laboratories.

It was September and the cool, crisp air in Gainesville was tainted only by the reminder that the paper mills of Jacksonville were only 70 miles away.

Our first acquaintance was made in the student lounge where Bruni and Frank Herrero told tall tales of their stint as orderlies and technicians in the Jackson Memorial Hospital. They further intimidated those of us who had never seen blood by handily beating us in the game of hearts. The Queen of Spades rode high for the next four years.

Room M-112, Medical Science Building—that's where it really began. The innovations were obvious as we sat in moveable, comfortable chairs with writing arms flexed in positions to aid note taking as we watched the retractable black boards and screens lurch into their hiding places, simply to be returned to their position of function upon command from the speaker. The lights, responded to a simple command and changed into ten positions designed to best illustrate those hidden wonders of cells and such.

Dr. George Harrell, first Dean of the Medical School, stood Lincolnesque in Room M-112 MSB before that august body to unveil his masterpiece which was to declare him a renown innovator in medical education. The study cubicle designed to fulfill the every need and desire of the medical student invited proper study habits by handsomely housing our books, lab coats, microscopes, black bag and goodies from mother.

The Author

JEAN LESTER BENNETT, M.D.

Dr. Bennett was a member of the University of Florida College of Medicine's first graduating class in 1960 and is now President of the University Medical Alumni. A loyal and avid "Gator," Dr. Bennett practices pediatrics in Clearwater and is a member of the Medical Advisory Committee to the Dean of the College of Medicine.



Dr. Bennett

Students were assigned in groups of four in all classes to enhance the spirit of camaraderie, thereby preparing us for the practice of the art of medicine.

Lab coats were gray by no accident to correspond to the gray matter that was to be exploited for the next four years. Vertical transportation was deemed the mode of travel for the years ahead. We were to become useful and wise having no knowledge; we had no conceit of knowledge.

Professors were introduced: Drs. Wilson, Odor, Goodman, Suter, Putnam, Fried, Koch, Olson, Edwards, Wood, Arean, Otis, Wright, Fregly, Maren. We thought as Socrates, "if there is anyone who has faith in oral instruction and in the reminiscence of ideas, with him we sympathize and hope that we may become like him."

The most memorable exam was in biochemistry where the Krebs cycle was to be explicitly drawn. In retrospect we should be grateful we were educated when there were so few amino acids, triglycerides were struggling to be chained, chromosomes were still 48 and prostaglandins were no where visible.

The first two years were blurs as we rushed toward the exciting clinical years. We were to be, "farmed out," to unsuspecting institutions beginning with the Lake City Veterans Administration Hospital. All of us climbed aboard the Blue Goose Bus and headed for rural Florida where Drs. Thomas, Taylor, Martin, Woodward and Stead taught physical diagnosis. The patients would extend their disease worn bodies from the window ledges as the young physicians arrived and yelled, "Here comes the wrecking crew!"

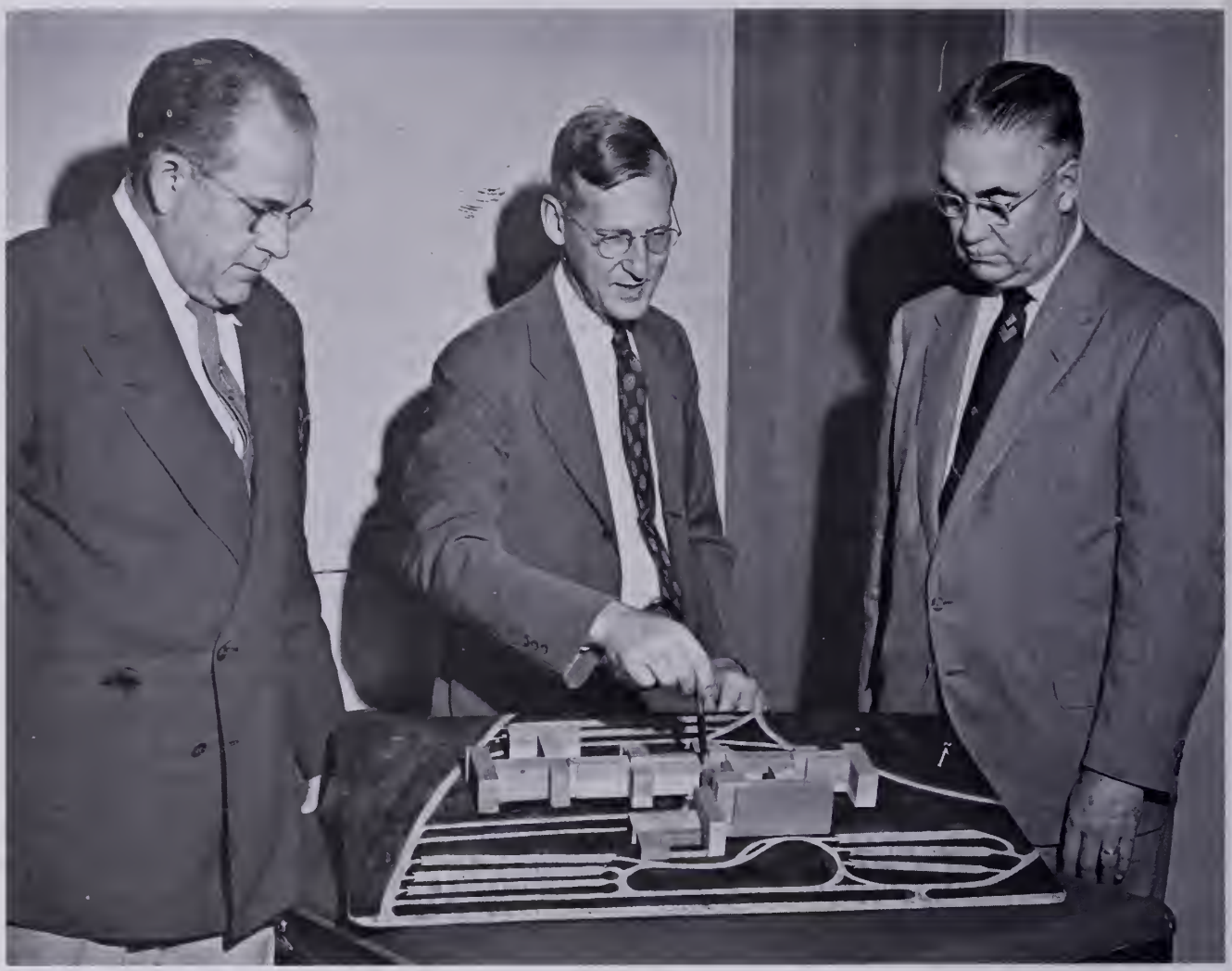


Fig. 2. —This block model of the University of Florida Health Center, showing the hospital side, is being explained by Dean George T. Harrell (center) to Dr. C. J. Van Slike, (right) director of the National Institutes of Health. Dr. Van Slike was a recent visitor on the campus for the purpose of discussing Health Center plans with D. Russell Poor, provost for the center (left) and Dean Harrell. (UF Photo)

Students were petrified as they simply tried to determine the chief complaint. Most of the veterans had been there for so long they had forgotten their chief complaint. One student of the team was to take the history, the other was to do the physical exam. There rarely was a correlation of history and physical findings and all were chagrined to discover we could not hear rales, mitral stenosis or feel thyroid glands.

Somehow the pain of failure was eased when the Blue Goose stopped at Howard Johnsons on the way back to Gainesville, so we could have a scoop of coconut ice cream.

Our next, "farm out," came in Jacksonville where we spent weeks at Duval Medical Center, Baptist Memorial and St. Luke's Hospital. Our lives were enriched by learning words such as, "fire balls", "clapps", and "throds" (thyroids).

State Boards were passed, National Boards in Room M-112 MSB threatened, and almost all courses were finished. We had done evil things like sing "Bridge Over the River Kwei" to our Colonel parasitology teacher as we entered to take the final. Also the Yekrut award (that's turkey spelled backwards) had been awarded to our worst professor. We'll never forget the aged William C. Thomas, Sr., M.D., who implored us to practice the art, love the family and love each other.

We loved—loved life, loved medicine, loved our family, loved the professors, loved the University of Florida and loved the thought of graduating and setting into motion the practice of the art we have achieved. There will never be a class at the University of Florida that loved each other so dearly or clung to each other for support the way we did. In room M-112 MSB we took the Oath of Hippocrates.

CLASS OF 60, COLLEGE OF MEDICINE, UNIVERSITY OF FLORIDA



We made it and here we are 20 years later:*

Name	Professional Activities
William R. Bailey, M.D. **Fort Sanders Professional Building** **501 Twentieth Street** **Knoxville, Tennessee 37916**	Professional Practice of Ophthalmology
Marvin I. Baker, M.D. **Chairman, Department of Radiology** **Kino Community Hospital** **University of Arizona** **Tucson, Arizona 85703**	Academic Medicine
Mark V. Barrow, M.D. **1130 N.W. 64th Terrace** **Gainesville, Florida 32601**	Private Practice of Adult Cardiovascular Diseases Diplomate, American Board of Internal Medicine Chief of Staff - North Florida Regional Hospital - 1976 Chairman, Board of Directors PSRO, Florida Area II President-Elect, Alachua County Heart Association
Jean L. Bennett, M.D. **1940 Drew Street** **Clearwater, Florida 33515**	Private Practice of Pediatrics University of Florida College of Medicine Advisory Committee to the Dean President, University of Florida Medical Alumni Association President-Elect, University of Florida Pediatric Alumni Association Past Chief of Staff-Morton F. Plant Hospital Clearwater Past Chairman of Credentials Committee, Morton F. Plant Hospital, Clearwater President, Board of Directors Child Guidance Clinic Board of Directors, Upper Pinellas County Association of Retarded Children Recipient of the International Seroptomist Award for Service to the Community through Medicine Recipient of the Award from Delta Gamma for Outstanding Teaching in the Community Athletic Council-Dunedin High School Board of Directors, Pinellas County University of Florida Alumni Charter Member, Clearwater Historical Society, Inc. Honorary Member, Delta Kappa Gamma Sorority Lecturer in Childbirth Preparation Classes, LaMaz, and Sexual Development for Junior High School
Billy R. Blakey, M.D. **331 N. Maitland Avenue** **Maitland, Florida 32751**	Private Practice of Family Medicine Masonic Lodge
Kay Miller Buchanan, M.D. **1941 East A Street** **Torrington, Wyoming 82240**	Private Practice of Obstetrics and Gynecology Diplomate, American Board of Obstetricians & Gynecologists Governance Committee for State, Library and Community Education
John F. Cluxton, M.D. **Deceased 5/28/78**	
Vincent V. Cremata, Jr., M.D. **845 Via Lombardy** **Winter Park, Florida 32789**	Not practicing medicine at the present time Rare Stamp Dealer, specializing in large investment accounts
J. Lawrence Dohan, M.D. **One Heritage Mall** **Berlin, Massachusetts 01503**	Private Practice of Internal Medicine and Dermatology President of Staff-Marlboro Massachusetts Hospital Chairman of the Board, Longfellow Racquet Club Chairman of the Board, Bezonian International
Betty (Robinson) Drake, M.D. **11809 N. Dale Mabry Highway** **Tampa, Florida 33618**	Private Practice of Pediatrics
A. Ronald Eckels, M.D. **Marshall Taylor Building** **835 Prudential Street** **Jacksonville, Florida 32207**	Private Practice of Urology Clinical Assistant Professor of Urology-University of Florida Boy Scouts of America-Assistant Scout Master Diplomate, American Board of Urology

* For those of you who were unable to respond to the profile questionnaire, only the practice activity is listed.

Name	Professional Activities
H. James Free, M.D. **1251 Lakeview Road** **Clearwater, Florida 33516**	Private Practice of Internal Medicine, Board Certified 1967, Re-Certified-Internal Medicine, 1977
Steve H. Gilman, M.D. **1500 S. Magnolia Extension** **Suite 104** **Ocala. Florida 32670**	Private Practice of Orthopaedic Surgery Florida Morgan-Horse Association 1978-80 Board of Trustees-Monroe Memorial Hospital (Chairman 1977-78) Board, Southeastern Livestock Pavilion Board, Marion Saddle Club University of Florida College of Medicine Advisory Committee to the Dean, 1972-1977 University of Florida Horse Program Advisory Committee Board of Directors, University of Florida Medical Alumni President Marion County Medical Society, 1974-75 Distinguished Service Award Jaycees Outstanding Service Award, Florida Council on Crime and Delinquency Diplomate, American Board of Orthopaedic Surgery
Morton S. Glickman, M.D. **Permenente Medical Group** **3284 Jefferson Street** **Napa, California 94558**	Private Practice of Family Medicine Diplomate, American Board of Family Practice NAPA Wine Tasters Club, Silvarado Country Club
Bruce E. Greenfield, M.D. **403 Wisconsin Avenue** **Beloit, Wisconsin 53511**	Private Practice of Family Medicine
Brunildo A. Herrero, M.D. **Watson Clinic** **1600 Lakeland Hills Boulevard** **Lakeland, Florida 33801**	Private Practice of Internal Medicine and Gastroenterology
Francisco A. Herrero, M.D. **775 Briarwood Drive** **Daytona Beach, Florida 32014**	Private Practice of Plastic Surgery Diplomate, American Board of General and Plastic Surgery President of Medical Staff, Halifax Hospital Medical Center, Daytona Beach, FL.
Richard F. Leeds, M.D. **California Health Service, SUR** **Audits and Investigations Division** **100 Mission Street, #903** **San Francisco, California 94105**	Medical Consultant to California Department of Health Board Eligible, Internal Medicine American Society of Internal Medicine American Association for the Advancement of Science Federation of American Scientists President, Condominium Association in San Diego
Donald N. Logsdon, M.D. **Brookdale Hospital Center** **Linden Boulevard-Rockaway Parkway** **Brooklyn, New York 11212**	Private Practice of Internal Medicine and Preventive Medicine Diplomate, American Board of Preventive Medicine, 1968 Hermann Biggs Society New York Academy of Medicine Medical Director, Prepaid Group Practice Assistant Clinical Professor, Mt. Sinai School of Medicine, New York City
Luther C. McRae, M.D. **Box 216** **Mt. Vernon, Georgia 30445**	Private Practice of General Practice
Charles R. Metzer, Jr., M.D. **LaVista Perimeter Office Park** **Building 6, Suite 110** **Tucker, Georgia 30084**	Private Practice of Pediatrics President, Greater Atlanta Pediatrics Society Board of Trustees, Christian Medical Society Gideons International, President North Atlanta Camp
Thomas J. Noto, M.D. **Baptist Hospital** **8900 N. Kendall Drive** **Miami, Florida 33176**	Director, Cardiovascular Laboratory, Baptist Hospital of Miami, Incorporated Fellow, Society for Cardiac Angiography
Charles T. Ozaki, M.D. **302 Duval Street** **Lake City, Florida 32055**	Private Practice of Pediatrics Past President of the Columbia County Medical Society Past Chief of Staff, Lake Shore Hospital Past Member, Child Health Committee for the Florida Medical Association Rotary Club Past Director, Chamber of Commerce American Legion Biological and Human Relations Committee of Veterans Administration Hospital

Name	Professional Activities
Roger F. Palmer, M.D. **Chairman, Dept. of Pharmacology** **University of Miami School of Medicine** **1600 N.W. 10th Avenue** **Box 016189** **Miami, Florida 33101**	Academic Medicine Chairman, Dept. of Pharmacology University of Miami School of Medicine Markle Scholar in Academic Medicine, 1965 Student Annual Teaching Award Outstanding Teacher in Basic Sciences, 1965 & 1968 Basic Science Teaching Award 1975 American Therapeutic Society Prize Essay Award, 1970 Meritor Service Award, American Heart Association, 1972
James W. Patray, Jr., M.D. **Palmetto Street** **Keystone Heights, Florida 32656**	Private Practice of General Practice Rotary Club
Howard I. Pryor, M.D. **1100 62nd Avenue South** **St. Petersburg, Florida 33705**	Private Practice, Family Practice
Eyvin P. Rasmussen, M.D. **33 Collier Road, Suite 305** **Atlanta, Georgia 30309**	Private Practice, Radiology, Ultrasonography Secretary, Georgia Radiological Society AMA Physicians Recognition Award Lasser Sailboat Fleet Captain, Atlanta Yacht Club Diplomate, American Board of Radiology
Neil J. Rohan, M.D. **150 Westward Drive** **Miami Springs, Florida 33166**	Private Practice, Orthopaedic Surgery Clinical Instructor, Orthopaedic Surgery, University of Miami Diplomate, American Board of Orthopaedic Surgery-1971 Miami Orthopaedic Society Florida Orthopaedic Society American Association of Orthopaedic Surgeons
John T. Simpson, Jr., M.D. **2416 E. Plaza Drive** **Tallahassee, Florida 32303**	Private Practice, Pediatrics
Samuel W. Smith, M.D. **P.O. Box 6097** **Lee Memorial Hospital** **Miracle Mile Station** **Ft. Myers, Florida 33901**	Private Practice, Radiology Diplomate, American Board of Radiology
B. Louie Stalnaker, M.D. **5120 Bayou Boulevard** **Pensacola, Florida 32503**	Private Practice, Obstetrics and Gynecology
A. Warren Sweat, M.D. **511 66th Street North** **St. Petersburg, Florida 33710**	Private Practice, Pediatrics Started Cystic Fibrosis Clinic Diplomate, American Board of Pediatrics ACH-1967
L. Paul Travis, M.D. **Director** **Department of Human Resources** **Box R** **Rehabilitation Center for Alcoholics** **Occoquan, Virginia 22159**	Private Practice, Psychiatry
Joseph A. Walton, Jr., M.D. **University of Michigan** **Department of Internal Medicine** **1405 E. Ann** **Ann Arbor, Michigan 48104**	Academic Medicine Director, Cardiac Catheterization Laboratory, University of Michigan School of Medicine Diplomate, American Board of Internal Medicine Diplomate, American Board of Cardiology
Edward R. Westmark, M.D. **5225 Carmel Heights Drive** **Pensacola, Florida 32504**	Private Practice, Neonatology Diplomate, American Board of Pediatrics Diplomate, Specialty Boards in Neonatal-Perinatal Medicine Florida Pediatric Society
John O. Whitehurst, M.D. **St. Francis Medical Park** **Manchester Road** **Columbus, Georgia 31904**	Private Practice, Head and Neck and General Surgery American Board of Surgery MacCombs Society Professional Education Committee American Cancer Society-Local Chapter Board of Directors, American Cancer Society-Local Chapter
Peter R. Whitis, M.D. **100 Langworthy** **Dubuque, Iowa 52001**	Private Practice, Child, Adult Family Psychiatry Diplomate, American Board of Psychiatry and Neurology American Psychiatric Association

Name	Professional Activities
S. Russell Wilson, M.D. **3701 Broadway** **West Palm Beach, Florida 33407**	Private Practice, Neurology Chairman, Department of Neurology St. Mary's Hospital West Palm Beach, Florida Chairman, Department of Neurology Good Samaritan Hospital West Palm Beach, Florida American Academy of Neurology Past President, West Palm Beach Sertoma Club Past District Governor, Southeast Florida Sertoma Director, Muscular Dystrophy Clinic, Regional American Heart Association-Community Services Past Director, Palm Beach Runner (and Founder)
George W. Wirtanen, M.D. **University Hospital of Wisconsin** **Department of Radiology** **1300 University Avenue** **Madison, Wisconsin 53706**	Academic Medicine Professor of Human Oncology and Radiology Director, Radiation Oncology Associate Director, Wisconsin Clinical Cancer Center Diplomate, American Board of Radiology Chairman, XII International Congress of Radiology, General Session, Tokyo, Japan, October 1969

Name	Professional Activities
	Selected as Biennial University of Wisconsin Exchange Professor to University of Helsinki, Finland, 1972, funded by an Educational Grant, 1972 Visiting Professor, University of Helsinki, 1973 Visiting Professor, University of Helsinki, Radiation Therapy Clinic, 1976 Visiting Professor, Department of Radiology, University of Bergen, Norway, 1979 Visiting Professor of University of Helsinki, Finland, Radiation Therapy Clinic, July, 1979
Edward H. Wood, M.D. **Fittsimmons Hospital** **Division of Cardiology** **12101 E. Colfax Avenue** **Denver, Colorado 80240**	U.S. Air Force Medical Corps/Cardiology and Internal Medical Cardiology Fellowship Training, 1978-1980 Society of Air Force Physicians Air Force Commendation Medal Meritory Service Medal United States Air Force Air Medal United States Air Force Vietnam Service Medal Armed Forces Expeditionary Service Medal (Congo)

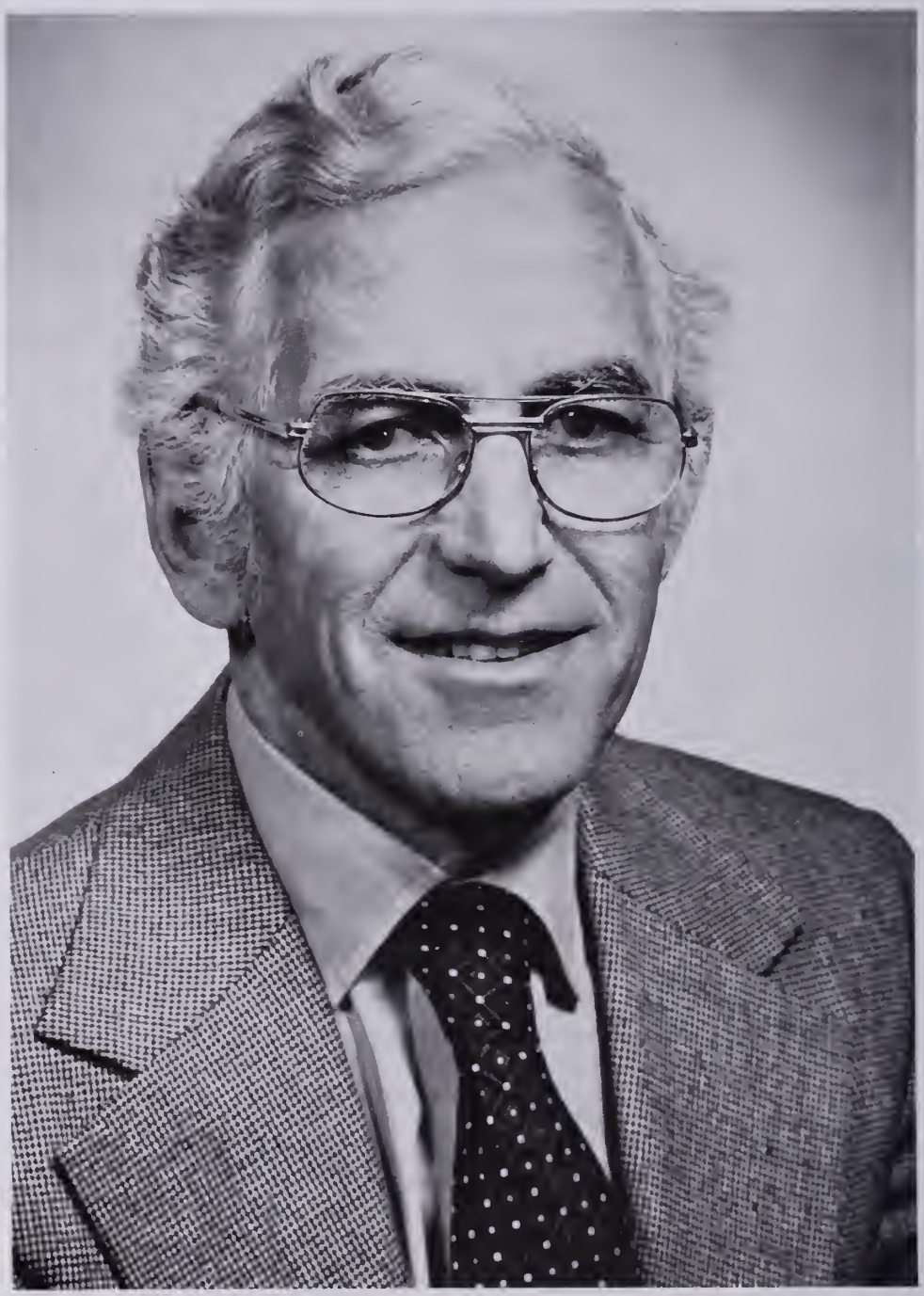
Room M-112 Medical Sciences Building—that's where it all began and in March, 1980, 39 of us will recommit our love to each other, and to the University of Florida that provided all of us, even the one from Woodbine, Georgia, a chance to practice the greatest art in the world.

39—that's all that will be there in Room M-112, MSB. John Cluxton (Clux) is gone!

- Dr. Bennett, 1940 Drew Street, Clearwater 33515.

The highest reward for man's toil is not what he "gets for it," but what he "becomes by it."

Ruskin



Emanuel Suter, M.D.
Dean, University of Florida
College of Medicine
1965 - 1972

Reflections on an Educational Program

Emanuel Suter, M.D., Parker A. Small Jr., M.D.,
Leighton E. Cluff, M.D., and C. Benjamin Stevens, M.A., M.S.

Abstract: This paper reviews the process whereby the University of Florida College of Medicine changed its educational program in 1969 from a classic curriculum (2 years basic science followed by 2 years of clinical medicine) to the A-B-C curriculum (A—1 year basic science, B—1 and ½ years clinical medicine, C—1 and ½ years elective). Now, given the perspective of a decade, some lessons emerge which may be of interest to those who experienced the changes and to those who will be involved in creating new changes.

> "The only man who is educated is the man who has learned how to learn; the man who has learned how to adapt and change; the man who has realized that no knowledge is secure, that only the process of seeking knowledge gives a basis for security."
>
> Carl R. Rogers, (1969)

Introduction

Among the many tasks and functions of medical schools, the educational program for medical students is the concern of all departments and their faculty members. Thus, medical schools, their departments and individual faculty members strive to offer the medical students what they consider a first rate program in an environment conducive to learning.

In general, the average faculty member of a medical school is selected on the basis of research potential or accomplishment and qualifications as a clinician; rarely does he or she have special training in education, instructional design or evaluation. This no doubt contributes to the tradition that the concerns of medical school faculties are directed toward content rather than design of educational and training programs. The educational program or curriculum is considered a means by which the faculty transfers knowledge and experience to the students, with some faculty members being more skillful at the task than others.

Stimulated by events from inside and outside medicine, medical school faculties began to explore new modes of curricular design during the fifties and sixties. Some of these events were: (a) the expansion development of biomedical research increasing the opportunity to enlarge the science base of medical practice, (b) the students' demand for relevance to the perceived role of the physician, (c) the public demand for readily available general primary care provided by community oriented physicians, (d) the formulation of new educational principles of learning, particularly adult learning, and (e) the emergence of new communications technology as a potential modifier of medical practice and education.

The Authors

EMANUEL SUTER, M.D.

Dr. Suter, a former Dean of the University of Florida College of Medicine, is now associated with the Association of American Medical Colleges in Washington, D.C.

PARKER A. SMALL JR., M.D.

Dr. Small formerly was Chairman of the Department of Immunology and Medical Microbiology and Chairman of the Phase A Committee. He is now Professor of Immunology and Medical Microbiology.

LEIGHTON E. CLUFF, M.D.

Dr. Cluff formerly was Professor and Chairman of the Department of Medicine and Chairman of the Phase B Committee at the University of Florida and is now Vice President of the Robert Wood Johnson Foundation in Princeton, N.J.

C. BENJAMIN STEVENS, M.A., M.S.

Mr. Stevens was associated with the Office of Medical Education at the time of the educational program change. He is now Director of that Office.

U.S. medical schools responded to those events with curricular reforms of various kinds (Hubbard et al., 1970), and the University of Florida College of Medicine was no exception. In the early sixties, the College of Medicine's curriculum committee became engaged in an indepth review of the curriculum and recommended major changes in December 1965. In response, the College appointed a new Educational Program Planning Committee (EPPC) chaired by the Dean, with the charge of developing a blueprint for an educational program as a key element of a general development plan for the College of Medicine for the seventies. The EPPC reported to the faculty in April 1967 (Suter, 1967). The basic assumptions leading to the program proposal, the process of implementation, evaluation data and further curriculum developments are summarized. Finally, some retrospective reflections are presented.

Assumptions and Requirements

The following assumptions were the basis for the EPPC's deliberations:

1. The program leading to the M.D. degree (medical school curriculum) is considered one phase of the lifelong continuance of learning of the student of medicine, bounded by premedical and graduate medical education programs (Figure 1).

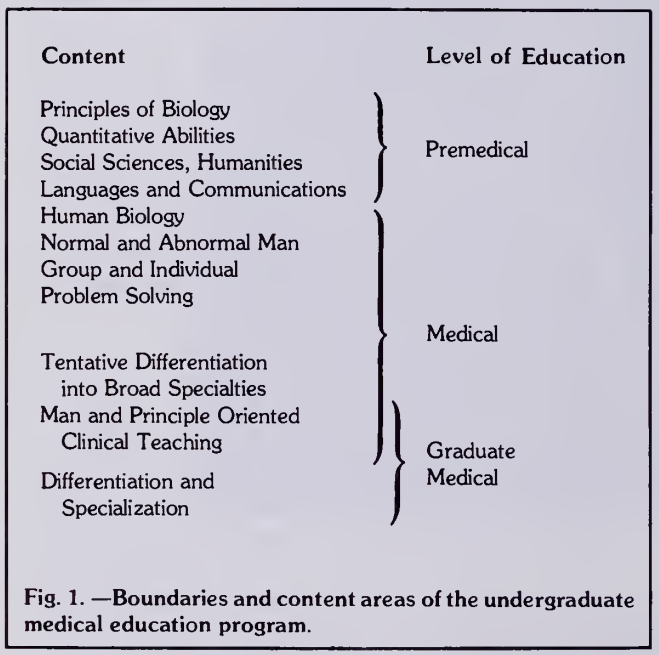


Fig. 1. —Boundaries and content areas of the undergraduate medical education program.

2. The acquisition of self-directed learning skills is an important or possibly an integral part of the preparation for medical practice.

3. The high level of motivation of the entering medical student toward clinical practice should be sustained by the instructional program.

4. The students should increasingly participate in establishing their own learning objectives.

5. The basic science and the clinical aspects of medicine should be presented as a whole rather than as irreconcilable and separate component parts.

6. Special attention should be given to problem solving skills for later clinical practice.

7. The educational program should be responsive to changes in the environment, the profession and the student body, and to advances in the sciences basic to medicine (biomedical, behavioral, communications).

8. The program should accommodate student individuality in terms of past experiences, existing competencies and career goals.

9. Evaluation should serve to increase student accomplishment and program success, and provide feedback between students and faculty.

Implementation Process

1. To implement the proposed educational program, the combined commitment and involvement of faculty, students, departments and administration had to be encouraged and supported. A multitiered process was developed: (1) the EPPC involved 10 key faculty members (including chairmen of departments) some of whom subsequently assumed the chairmanships of Phase committees; (2) separate but overlapping committees for Phases A, B, and C were appointed (approximately 50 faculty members); (3) committees for individual topic areas involved about 200 faculty members; (4) the Faculty Council received program reports, conducted a final debate and approved the proposed educational program; and (5) progress reports were reviewed with the Medical Advisory Committee to the University.

2. To satisfy some of the requirements stated above, the program was divided into three phases as follows:

Phase A (1 year): **Biological Principles Relevant to Man and Medicine**

- Introduction to medical sciences
- Regulatory mechanisms and homeostasis
- Exogenous determinants of functions and reactions
- Development
- Biology of Behavior, ethology

Phase B (1-½ years): **Clinical Medicine**

- Reaction to injury
- Clerkships in the clinical disciplines
- Experiences in the specialties of medicine

Phase C (1-½ years): **Study in Depth in Medical Sciences**

- Basic and Clinical Science electives

3. By combining basic science and clinical faculty in both the **Phase A** curriculum committee and the instructional teams, it was hoped to accomplish a logical combination of clinical problem-solving with the acquisition of scientific knowledge. It was further anticipated that the contact with clinical faculty would sustain the students' interest and motivation for medicine and stimulate interest in the basic sciences as the necessary foundation for clinical problem-solving. The final plan for **Phase A** successfully incorporated most of the educational assumptions stated, and reconciled them at least temporarily with discipline or departmental needs.

4. These assumptions proved to be less compatible with the departmental concerns for **Phase B**. The EPPC perceived clinical training predominantly as the development of an intellectual and inner discipline for patient care, while the specific departments interpreted it as the acquisition of skills relevant to their respective disciplines. Nevertheless, the incorporation of a community medicine rotation in this period represented a constructive response to the perceived need of adding a new dimension to the clinical experience of the young physician.

5. The purpose of **Phase C** was unequivocal: to permit the student a voice in the setting of learning objectives through the selection of elective courses, to bring the student back to the basic and clinical sciences for indepth study, and to challenge the student as a self-directed learner. The procedural complications were many and ultimately became a major source of dissatisfaction for the faculty.

6. At the time of the program's approval by the faculty, the College of Medicine received a federal construction grant for major expansion of its facilities. Some of these facilities were designed to serve as an environment essential for the implementation of the program, particularly by facilitating self-directed study.

Outcomes and Evaluation

Assessment of the outcome of an educational program revision is a difficult and nearly impossible task. To arrive at a fair judgment an independent evaluator is required. The EPPC established specifications, though incomplete, for evaluation which included:

- Administration of the Mini-test developed by the NBME* to the classes upon entry and at the conclusion of each year.
- Administration of NBME examination, Parts I and II, upon completion of Phase B.
- Program examinations for the various units of each phase.
- Evaluation of the student's behavior, attitude, study habits, etc.
- Administration of a questionnaire regarding particulars of student experiences in the basic sciences as they relate to medicine.

1. **Student Learning:** To assess student learning both NBME Mini-tests and Part I and II examinations were utilized. The Mini-test was prepared and offered by the NBME between 1969 and 1978 to serve as a tool to assess on a yearly basis the students' progress in the basic and clinical programs. Figure 2 shows the performances of the classes of 1971 through 1978 on the Mini-test (the class of 1972 was the last class under the old curriculum and the class of 1973 the first taking the new educational program).

The classes of 1971 and 1972 (prior to the institution of Phases A, B, and C) show a distinct flattening of basic science scores after the second year. The basic science scores of the class of 1973 through 1975 show a rise beyond that of the classes of 1971 and 1972 continuing through year four. The

*National Board of Medical Examiners, Philadelphia, PA

classes of 1976-1978 (the Mini-test was discontinued for classes after 1978) while showing a similar increase in years 1 and 2 albeit 1-2 points lower, present a sharper falloff in year 3 than the classes of 1973 through 1975.

This lessening of scores and decrease in slope is just as evident in the clinical science scores of the classes of 1976-1978. This mean of student accomplishment, while significantly higher than that of the classes of 1971 and 1972, seems to have an upward slope of lesser magnitude than that of the classes of 1973 through 1975.

The NBME examination, Parts I and II, was administered under changing policy (sometimes a passing score was required for graduation and sometimes not). It is well documented that changes in such policy profoundly affect results (Hubbard, 1978). Therefore, the scores are not considered in this context.

2. **Student Attitude**: At the conclusion of Phase A, each class was given an attitudinal questionnaire. The classes of 1970-72 were also surveyed but only in June of 1970 (the end of years 4, 3, or 2 respectively). The results obtained with selected questions are shown in Table 1. The data show significant improvement in attitudes after initiation of the new program. In later years, however, a reversal seems to have occurred to an attitudinal index closer to the original pattern.

There is little doubt that a majority of the students seemed to perceive the program innovations as facilitating motivation, learning and pursuit of personal interests. Some students were able to benefit from the opportunity for self-direction in Phase C while others were incapable of responding in a fully responsible fashion. After several years of operation of the new program it seems that student enthusiasm and interest waned. Whether this was a primary reaction or a response to faculty dissatisfaction is difficult to assess without further data and analysis. Nevertheless, student surveys conducted prior to graduation of the class of 1974 and 1975 indicate strong student support for this program.

3. **Faculty Responses**: There is little doubt that the majority of the faculty responded with enthusiasm to the challenges of the new program. Initially, the faculty seemed to gain in perspective as teachers and formed new collegial relationships. However, the increasing demand on faculty time to

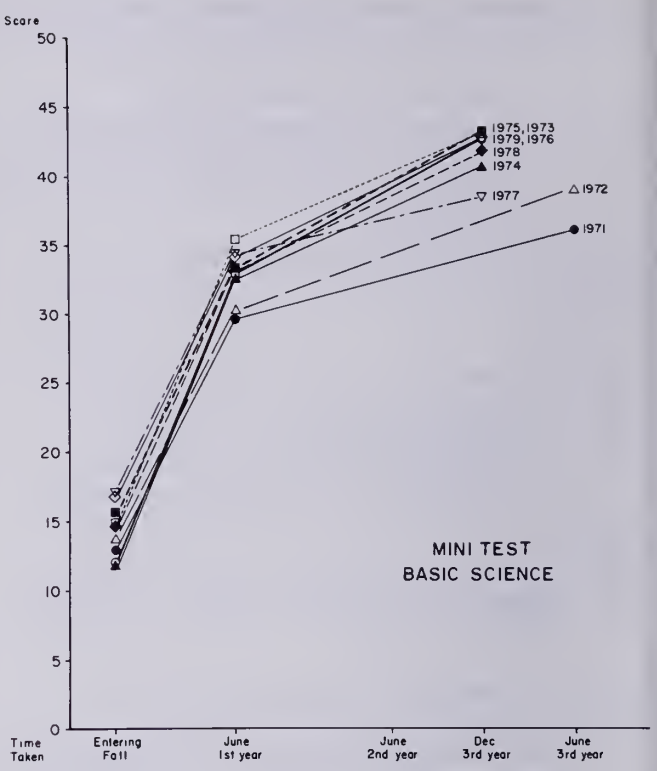


Fig. 2a. —Average scores obtained on the basic science portion of the NBME Mini-test over subsequent years by members of the classes of 1971 through 1978.

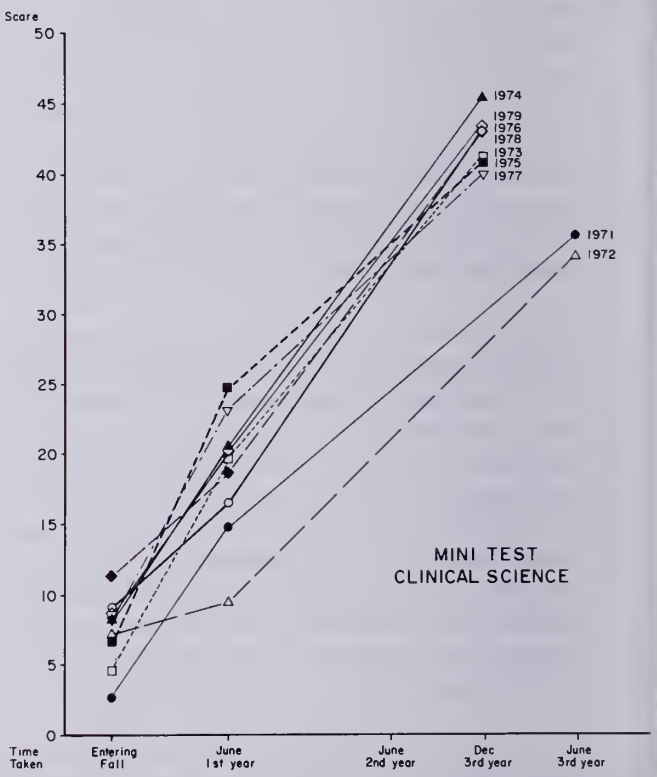


Fig. 2b. —Average scores obtained on the clinical science portion of the NBME Mini-test in subsequent years by members of the classes of 1971 through 1978.

Table 1

Response to selected questions of attitudinal questionnaire administered to students after completion of Phase A.

Question 1: Curriculum strengthened relvancy of basic medical sciences for career in medicine: N = ( )

	Class—1972 (48)	1973 (59)	1976 (54)	1983 (45)
highly	40%	73%	57%	60%
moderately	50%	25%	42%	38%
little	10%	2%	2%	2%
not at all	0%	0%	0%	0%

Question 2: After last year's experience your respect for medicine is:

	Class—1972	1973	1976	1983
much more	17%	23%	14%	5%
somewhat more	20%	43%	25%	21%
same	36%	25%	33%	45%
somewhat less	21%	9%	16%	22%
much less	5%	0%	12%	7%

Question 3: Last year's experience strengthened motivation toward medicine:

	Class—1972	1973	1976	1983
yes	54%	89%	57%	62%
no	46%	11%	43%	38%

carry out the original planning and continuing maintenance of the program seems to have been a cause of weakening of their enthusiasm and support for this program. Furthermore, the fact that the program had lost identification with specific disciplines or programs was another cause for dissatisfaction.

4. **General Outcome:** A first evaluation retreat held in the summer of 1972 resulted in the return to letter grades of students in Phase A instead of the pass—fail system. A comprehensive evaluation document was developed in 1975. The evaluation included a student questionnaire from the classes of 1974 and 1975, NBME Parts I and II, and Mini-test performance data and assessment reports by the chairmen of Phase A, B, and C Committees. Student evaluation of the program appears to be favorable both in terms of perception of overall time allocations, attitudes and general satisfaction.

Despite this relatively positive report, overall interest of the faculty in the program declined. They seemed to prefer a return to more discipline oriented instructional schedules even at the expense of some of the assumed educational principles. In the absence of documentation, a number of recent decisions regarding the program must be considered a consequence of this general sentiment. During this critical phase of the educational program the College of Medicine has experienced leadership changes with all the accompanying shifts of influence and power. Concurrently, all medical schools in the United States have begun to feel the consequence of inflation and the changes in sources of support with a decline in the rate of growth.

Discussion

The review of the planning, development, implementation and ultimate fate of the educational program at the University of Florida College of Medicine is fascinating, especially to those who played major participatory roles. The experience should also be of interest to others because of the general issues associated with educational change and innovation. The following comments are offered in the hope that they will be helpful to future generations of enthusiastic innovators and change agents. Those privileged to participate in this development had an invaluable experience, at times painful, and would like to share some of it.

1. Any major change of an undergraduate medical educational program should have broad support from students, faculty departments and administration in order to create a favorable attitudinal environment for the initial and sustained efforts required.

2. The majority of the faculty should be aware of the tasks involved and the specific contributions required from each individual. If new concepts, attitudes and skills are involved, the faculty needs ample opportunity to become familiar with these concepts and acquire the necessary skills.

3. Many recent educational program changes question and infringe on disciplinary or departmental territories. Potential conflicts have to be recognized and should be dealt with in a decisive fashion. Particular attention must be given to the potential risk of creating an administrative structure for the educational program which could be at odds with the usual lines of authority of the college and the departments. If at all possible administrative unity should be preserved.

4. Program evaluation requires careful consideration. It should address program performance and outcomes and should involve students and faculty. For instance, there is no question that the students

learned and made satisfactory progress. It is also clear that a significant number of them experience satisfaction with the program. However, we cannot tell whether these students have become better learners to bring a fresh outlook to the task of continuing education. Only a longitudinal study following the graduates well into practice could measure this parameter.

5. A major handicap in evaluating program change is the inability to measure clinical competence of the young physician. In the absence of valid methods we have to resort to judgment based on observations of performance of the individual and to established cognitive measures.

6. Confusion between feedback and grading should be avoided. During the first few years Phase A students were graded on a pass-fail basis, but this grading system led to feelings of insecurity on the part of both students and faculty, particularly when students applied for internships. Both groups subsequently voted to return to a more classic evaluation system. Retrospectively, it is clear that what both students and faculty needed was feedback so that both parties could be assured that learning was taking place. Grading is one way to provide feedback, but it certainly is not the only way to do so.

7. The erosion of interest in the new program among many of the participants, students, faculty, departments and administration may create sufficient dissonance or lethargy to endanger the survival of the program. There is a continuing need for review, reaffirmation and renewal.

8. The validity of the assumptions made by the Educational Program Planning Committee was not tested. A later extensive search of the learning literature by one of the authors (E.S.) confirmed their theoretical validity. In retrospect it appears that additional basic tenets of medical education were not stated, such as physician responsibility, accountability and discipline. These latter attributes have received broader attention in recent years, a clear indication of the changing environment in which education occurs.

9. Finally, looked at from some distance, curriculum changes seem to be cyclic events driven by forces internal and external to the institution. The University of Florida College of Medicine responded in the sixties to these stimuli with substantive changes in its educational program. Fifteen years later, it seems again to undergo adaptation and change. The lesson may be that students benefit more from energy devoted to improve instruction and facilitate learning within an existing curriculum rather than from extensive program changes *per se*.

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• Dr. Suter, One Dupont Circle, N. W., Washington, D. C. 20036.

The best way to succeed in life is to act on the advice we give others.

The Present Curriculum

Phase A

Phase A occupies the entire first year, followed by vacation in the summer quarter. A fall quarter is devoted to a study of biochemistry and molecular genetics, gross anatomy, embryology, and an introduction to clinical medicine. Teaching in all quarters is of an interdisciplinary, interdepartmental nature, with teaching teams drawn from both the basic and clinical departments. The course schedule is broken down in the following manner:

Biochemistry and Molecular Genetics consists of lectures and discussion sessions designed to increase the student's basic biochemical knowledge of cellular functions in health and disease including genetic disorders. The nutrition, physical chemistry, metabolism, and molecular biology of mammalian cells are stressed including such subjects as homeostasis, inborn errors of metabolism, cell genetics, and medical aspects of human genetics.

Gross Anatomy represents an introduction to the basic structure and mechanics of the human body. The dynamics of learning occur primarily in the laboratory and are supplemented with lectures, conferences, and demonstrations as needed.

Embryology covers early human development including gametogenesis. The major emphasis of the course will be on normal human organ development and morphogenesis. A system approach, correlated with the normal gross anatomy of those systems, will be used.

Introduction to Clinical Medicine is an integrated course given throughout the three quarters of Phase A. Applications of basic science principles to clinical problems are presented and discussed.

Microscopic Anatomy is a course in which the microscopic structure of the cells, tissues, and organs of the human body is taught. Correlation of structure and function is emphasized.

Human Systems I introduces general physiology and microscopic anatomy and proceeds with in-depth interdisciplinary studies of the hematopoietic system, and the respiratory, cardiovascular, endocrine, gastrointestinal, renal, and reproductive systems.

Human Systems II teaches the nervous system first and then presents the microbe-host interactions and the pathological consequences of infection. Again the approach is an interdisciplinary one.

Introduction to Human Behavior deals with the human life cycle and the different psychosocial factors affecting the physician and the patient. Individual students or groups of students interview patients under the supervision of the psychiatry and general medical-surgical faculty.

YEAR I

<table>
<tr><th>FALL QUARTER</th><th>WINTER QUARTER</th><th>SPRING QUARTER</th></tr>
<tr><td>BIOCHEMISTRY AND MOLECULAR GENETICS (BMS 5201C)</td><td rowspan="2">HUMAN SYS. I (BMS 5000)
Physiology
of
Cardiovascular
Endocrine and Reproductive
Gastrointestinal
Respiratory
Renal</td><td rowspan="2">HUMAN SYS. II (BMS 5001)
Neuroscience
Immunology
Microbiology
General Pathology</td></tr>
<tr><td>GROSS ANATOMY (BMS 5100C)</td></tr>
<tr><td>EMBRYOLOGY (BMS 5121)</td><td>MICROSCOPIC ANATOMY (BMS 5100)</td><td>INTRODUCTION TO HUMAN BEHAVIOR (BMS 5002)</td></tr>
<tr><td colspan="3">INTRODUCTION TO CLINICAL MEDICINE (BMS 5004)</td></tr>
</table>

Phase B

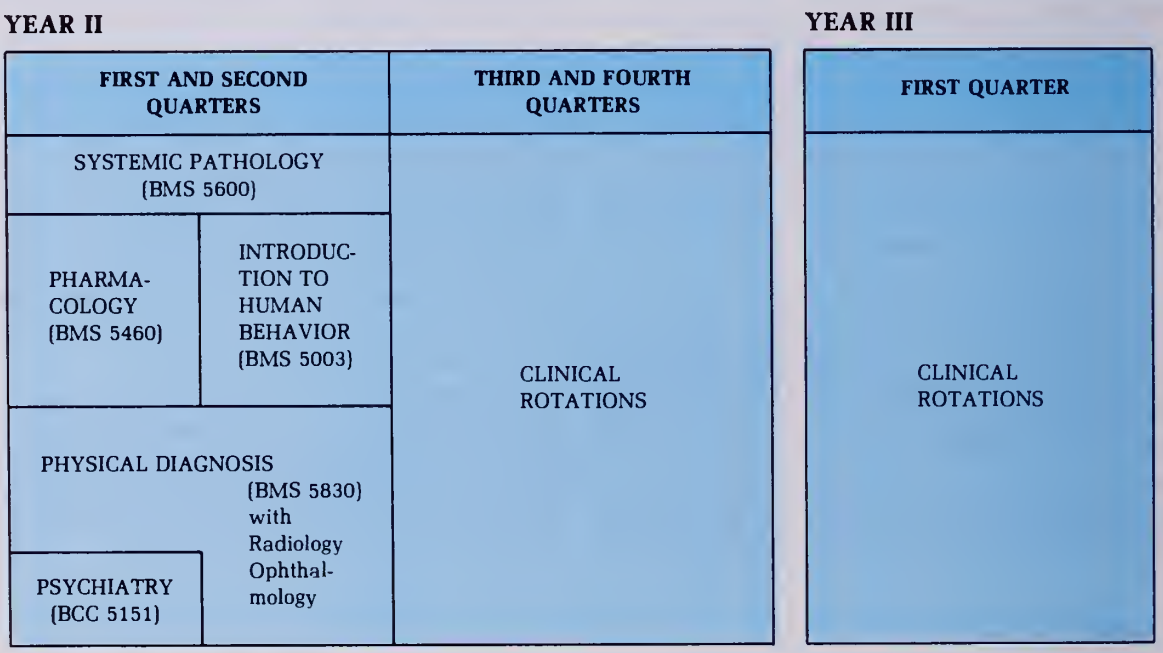
Phase B is designed to give a broad experience in clinical medicine. Diagramatically, it may be represented as follows:

Initial course work consists of Systemic Pathology, Physical Diagnosis, Pharmacology, and Community Medicine. Systemic Pathology will emphasize the effects of disease on the human organism and the correlation of disease with symptoms, signs and the course of illness. Physical Diagnosis is taught emphasizing anatomic and radiologic characteristics of children and adults. Experience in patient interview (psychiatry) is also provided. Laboratory diagnosis and introduction to Radiology are taught concomitantly to familiarize the student with diagnostic procedures. Community Medicine explores the patient's interactions associated with disease, treatment, family and community.

The major portion of Phase B is devoted to the clinical clerkships, in which groups of students will rotate among the major clinical services receiving direct patient contact. During the clerkships, the student becomes an integral member of the medical team and is responsible for the patient during all hours of the day or night.

Each clinical service conducts a variety of seminars and conferences. These are considered to be part of the clerkship and are also attended.

At the conclusion of Phase B, a review of particular basic sciences is held for 11 weeks including Clinical Pharmacology, Microbiology, and Pathophysiology.



Phase C

Phase C occupies the ten months of the curriculum and consists of elective experiences combined with two months clerkship (one month of Medicine and one month of Surgery).

The student thus is able to design a program which will permit extensive elective time in a clinical or basic science area, an early experience related to their career choice, or an exploration of interests among several career choices. Considerable freedom is permitted the student in designing their program, but the choices are made carefully in conjunction with the student's faculty and advisors. Remediation may take place in Phase C upon recommendation by the Academic Status Committee, appropriate department, and faculty advisor.

Any student academically below the middle of the class requesting to study away is required to obtain his advisor's permission. Any student whose request exceeds a three month period of study at other

YEAR III

SECOND, THIRD AND FOURTH QUARTERS	FOURTH QUARTER
CLINICAL ROTATIONS	Basic Science Review Clinical Pharmacology Microbiology /Infectious Diseases Pathophysiology

YEAR IV

FIRST, SECOND AND THIRD QUARTERS
CLERKSHIPS (2 months) ELECTIVES

institutions, is to be reviewed by the Academic Status Committee and/or the student's advisor. Each student is required to submit a written report of activities during this period.

The science requirement can be met by several different methods: (1) by registration in formal courses in the basic science departments, (2) by engaging in a research laboratory project with a member of the faculty, and (3) by engaging in a group project supervised by the faculty. The student also may elect to satisfy the science requirement in one of the other colleges, provided prior approval is received from an advisor and the dean.

Clinical assignments are available in all of the major disciplines of medicine. The student may work as an advanced clerk, assuming greater responsibilities than in Phase B, or in special cases may qualify for internship at an earlier time.

The Curriculum Committee, along with the Executive Committee, the faculty and dean are continually evaluating and refining the curriculum.

Make it a point to do something every day that you don't want to do. This is the golden rule for acquiring the habit of doing your duty without pain.

Mark Twain



William B. Deal, M.D.
Dean and Vice President for Medical Affairs
University of Florida College of Medicine
1977 -

Dean's Page

The Academic Pace Setters

William B. Deal, M.D.

As the College of Medicine celebrates the graduation of its twentieth class, it is clear that the achievements in education, research and service could not have been accomplished without leadership in key roles — the departmental chairmen. Tribute to them is in order because without their guidance and vision, the institution could not have gained the national stature that it currently enjoys.

The original cadre of chairmen assembled by the founding Dean, Dr. George Harrell, was responsible for the high quality academic pace of our College of Medicine.

Since medical schools are dynamic institutions, constant change is inevitable. Successors to the original group have continued to mold and expand the academic, research and service programs to their present status of excellence.

As disciplines developed broader scientific and service roles, new departments were formed: Ophthalmology, Anesthesiology, Neuroscience, Community Health and Family Medicine, Neurology, and Orthopaedic Surgery. The newest approved department, Neurological Surgery, will be fully functional within months.

No historical perspective of the College of Medicine would be complete without recognizing these talanted academic leaders. Therefore, our thanks should be extended to the following past and current chairmen:

Past and Current Departmental Chairmen

Anatomy

James G. Wilson, Ph.D.
Donald C. Goodman, Ph.D.
Michael H. Ross, Ph.D.

Anesthesiology

Joachim S. Gravenstein, M.D.
Jerome H. Modell, M.D.

Biochemistry

Frank W. Putnam, Ph.D.
Robert G. Langdon, M.D., Ph.D.
Peter A. Cerutti, M.D., Ph.D.
D. Michael Young, M.D.

Community Health and Family Medicine

Richard C. Reynolds, M.D.
Yank D. Coble, M.D.
J. Russell Green, M.D. (Acting)

Medicine

Samuel P. Martin, M.D.
Richard P. Schmidt, M.D.
Leighton E. Cluff, M.D.
James E. McGuigan, M.D.

Immunology and Medical Microbiology

Emanuel Suter, M.D.
Parker A. Small, M.D.
Kenneth I. Berns, M.D., Ph.D.

Neurology

Melvin Greer, M.D.

Neuroscience

Frederick A. King, Ph.D.
William Luttge, Ph.D. (Acting)

Obstetrics - Gynecology

Harry Prystowsky, M.D.
William N. Spellacy, M.D.
Eduard G. Friedrich, M.D.

Ophthalmology

Herbert E. Kaufman, M.D.
Melvin L. Rubin, M.D.

Orthopaedic Surgery

William F. Enneking, M.D.

Pathology

Joshua L. Edwards, M.D.
Richard T. Smith, M.D.

Pediatrics

Richard T. Smith, M.D.
Gerold L. Schiebler, M.D.

Pharmacology

Thomas H. Maren, M.D.
Allen H. Neims, M.D., Ph.D.

Physiology

Arthur B. Otis, Ph.D.

Psychiatry

Peter F. Regan, M.D.
Robert L. Williams, M.D.
John E. Adams, M.D.

Radiology

John D. Reeves, M.D.
Clyde M. Williams, M.D., Ph.D.

Surgery

Edward R. Woodward, M.D.

Henry E. Sigerist once said, "Medical history teaches us where we came from, where we stand in medicine at the present time, and in what direction we are marching. It is the compass that guides us into the future. If our work is not to be haphazard but to follow a well-laid plan, we need the guidance of history, and it is not by accident that all great medical leaders were fully aware of the value of historical studies."

Dr. Deal is Vice President for Health Affairs and Dean, University of Florida College of Medicine, Gainesville.

● Dr. Deal, University of Florida College of Medicine, Gainesville 32610.

The Office of the Dean



WILLIAM B. DEAL, M.D.
Vice President for Health Affairs and
Dean, College of Medicine



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Associate Dean for
Academic Affairs



HUGH M. HILL, M.D.
Associate Dean for Student and
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LAMAR CREVASSE, M.D.
Assistant Dean for
Continuing Medical Education



JAMES A. DEYRUP, Ph.D.
Assistant Dean for
Preprofessional Education



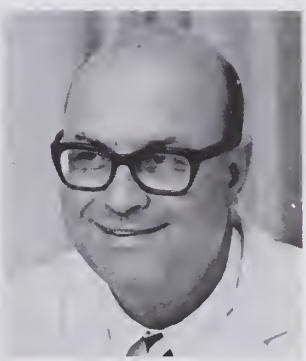
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Assistant Dean for Graduate
Medical Education



J. OCIE HARRIS, M.D.
Chairman Medical Selection
Committee



R. M. WHITTINGTON, M.D.
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Assistant Dean for Clinical
Affairs



ROBERT H. REEVES, Ph.D.
Assistant Dean for
Tallahassee Program

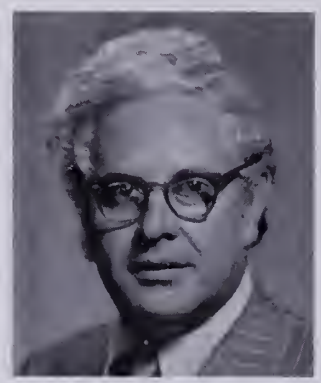


MAX MICHAEL JR., M.D.
Assistant Dean for
Jacksonville Programs

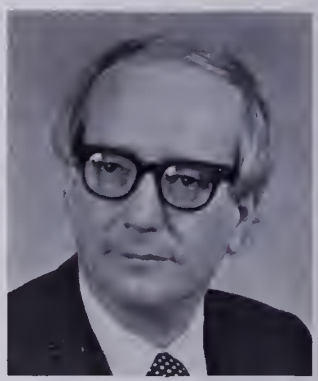
University of Florida College of Medicine Departmental Chairmen



MICHAEL H. ROSS, Ph. D.
Department of Anatomy



JEROME H. MODELL, M.D.
Department of Anesthesiology



MICHAEL YOUNG, M.D.
Department of Biochemistry ar
Molecular Biology



J. RUSSELL GREEN, M.D.
(Acting)
Department of Community Health
and Family Medicine



KENNETH I. BERNS, M.D., Ph. D.
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Department of Neurology



WILLIAM G. LUTTGE, Ph. D.
Acting Chairman,
Department of Neuroscience



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Department of Obstetrics &
Gynecology



MELVIN L. RUBIN, M.D.
Department of Ophthalmology



WILLIAM F. ENNEKING, M.D.
Department of Orthopaedic Surgery



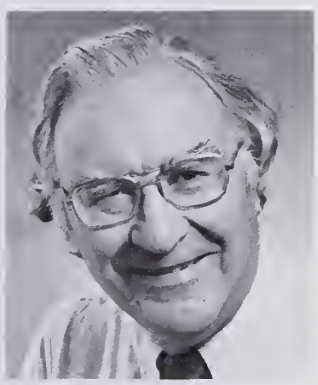
RICHARD T. SMITH, M.D.
Department of Pathology



GEROLD L. SCHIEBLER, M.D.
Department of Pediatrics



ALLEN H. NEIMS, M.D., Ph. D.
Department of Pharmacology and Therapeutics



ARTHUR B. OTIS, Ph. D.
Acting Chairman,
Department of Physiology



JOHN E. ADAMS, M.D.
Department of Psychiatry



CLYDE WILLIAMS, M.D., Ph. D.
Department of Radiology



EDWARD R. WOODWARD, M.D.
Department of Surgery

In Memoriam



Chandler A. Stetson, M. D.
Dean, University of Florida
College of Medicine
1972-1974
Vice President for Health Affairs
and Dean 1974-1977

Quality of Excellence

Chandler A. Stetson, M. D.

For the last fifty years, American medical schools have operated upon the premise that medical education programs must be of excellent quality if the profession of medicine is to be all that it should be, and if the American people are to have the best possible health care. It is to ensure the quality of excellence that our admissions committees have invested so much time and effort in trying to identify the best-qualified students, that we have emphasized the training and recruitment of able scientist-teachers and physician-teachers to our facilities and that such heavy investments have been made in the teaching facilities on our medical school campuses. The objective of all of this has been to provide highly qualified students with high-quality medical education, based on our conviction that the very nature of the profession of medicine leaves no room for mediocrity or inferiority and that our patients deserve nothing less than the very best that our system can provide, including the very best in medical education.

Recently, there have arisen some serious threats to that basic premise. In response to public and governmental concern over the "doctor shortage," most of our medical schools have undertaken massive expansion programs. This year, for example, over 14,000 students are enrolled in first-year medical school classes as compared to around 8,000 a decade ago. There has been a comparable expansion in the numbers of interns and residents, nursing students, dental students, pharmacy students and allied health professional students. Incentives have been offered to expand class sizes, shorten the curriculum, etc., but there are several indications that this concentration on sheer growth in numbers is resulting in erosion of quality in our teaching programs. In both public and private schools, funds from both governmental and private sources have not been adequate to keep up with the expansion of student class size. As a consequence not enough new faculty members can be hired, and the present faculties are consequently becoming older, overworked and a bit less likely to stay abreast of new developments in medicine. More and more across the nation, clinical faculty time is being too heavily invested in private practice fee generation, in an effort to help meet the medical schools' bills, rather than in teaching and in generation of new knowledge. Finally, federal cutbacks in support to medical schools have been severe, resulting in what amounts to austerity programs which have the flavor of holding actions rather than of vigorous improvement, growth and renewal. I don't mean to overstate the case and to suggest that we have an emergency or crisis situation. I *do* mean to say that there is clear evidence that we are caught in a slow drift away from the emphasis on quality and excellence that has pervaded the American medical school scene since the Flexner report sixty years ago. We must be scrupulously certain that efforts to make medical education (and medical care!) less costly do not result in sacrifice of quality.

We badly need a firm and stable national policy on medical education, on such matters as the numbers of students we should be educating. Opinions in Washington have blown hot and cold over whether or not there is a "doctor shortage." After several years of pressing our medical schools to expand, suddenly this year the official line in HEW is that we are training enough and maybe more than enough physicians by the early or mid 1980's. And yet, mirabile dictu, the Veterans Administration is right now offering "assistance grants" to affiliated medical schools if the medical schools will only agree to further expand their class sizes!

Those of us with responsibility for planning and management of our medical schools find it difficult to cope with federal policies that are here today and gone tomorrow. Too often our medical schools have been left holding the bag, with a commitment and investment in programs in which Washington suddenly decides it has no further interest. Our chief concern, in the last analysis, is for the quality of our educational programs which form the basis on which the standards of our profession rest.

The above article was published in the March, 1974, issue of the *Journal of the Florida Medical Association, Inc.* It is being reprinted in this issue to pay tribute to Dr. Stetson's memory and his lasting influence on the College of Medicine.

The Impact of a Medical School on the Private Practice of Medicine in the Community

Henry J. Babers Jr., M.D.

The Author

HENRY J. BABERS, JR., M.D.

Dr. Babers has been in the private practice of general surgery in Gainesville since 1946. He is a former Chief of Staff of Alachua General Hospital, past President of the Alachua County Medical Society and a Past President of the Florida Medical Association. At present he is Medical Director of the Community Medical Services and a member of the Medical Advisory Committee to the Dean of the College of Medicine of the University of Florida.



Dr. Babers

This is a description as to what happened to a small college town and its medical "family" when a College of Medicine was established at the University of Florida. This narrative is my own, but I believe the physicians in Florida will find it interesting. I was born in Gainesville, Florida, in 1912, went into the Army as a surgeon in World War II, straight from my surgical residency, and then came back home in late 1945, and then went into practice in Gainesville. In 1968, Mark V. Barrow, M. D., then a faculty member of the College of Medicine, wrote a "Short History of the University of Florida College of Medicine to 1960" (*Journal FMA* August 1968) in which he gives a clear picture of events which led to the establishment of the College of Medicine. I was living in Gainesville while most of the events he chronicles took place. (Incidentally, Dr. Barrow, a graduate of the class of 1960, is now a very successful cardiologist in private practice in Gainesville.)

Let me go back a few years: Through the years 1945 to 1965, Florida grew and grew. When I graduated from the University of Florida in 1932, with my B. S. degree, the student population was less than 4,000; the faculty was small in numbers; and so was the local medical community. The population of the University, the City, and Alachua County, grew steadily. Just before World War II, the younger doctors left for military service leaving only the older doctors. In 1945, after the war ended, Florida became very active. Tourism got big; people began to pour into Florida, especially into South Florida. The physician population of Gainesville gained very slowly. The physicians who had gone into military service came back, but very few younger doctors came. Conditions in Gainesville were *not* conducive to attracting new doctors. Citizens did not realize that it would be to their best interests to recruit top-rank doctors. Many citizens in South Florida communities *did* understand the factors and the young doctors went further South. The Alachua County community and its leaders did not realize that poor conditions and poor facilities equaled poor doctors and poor care! The only doctors who came to Gainesville between 1945 and 1960 (and later), were motivated by family ties almost completely. The local hospital and general attitude were so poor that recruitment of physicians was nil! Those people who were financially able went elsewhere for their care. The local medical fraternity took care of those who were less ill or less fortunate. During the period from 1945 to 1960, the population of Gainesville went from 15,081 in 1945, to 29,701 in 1960, and the population of Alachua County increased from 38,265 to 74,071. The student body increased rapidly, as did the faculty at the University of Florida. As a consequence, the physicians in practice were overextended and were called on to do things they were ill-prepared to do under local conditions. There was very poor support from the body politic! How the physicians stood it, I do not know; why we stayed in Gainesville when working conditions were better elsewhere, I do not know except to say that family ties (directly or through marriage) are strong. We were all tired to death and did not get enough sleep, relaxation, or time to study. We did treatments and procedures that were more stressful than satisfactory. In short, we were staggering under a heavy burden and were too tired to "see the woods for the trees". We were simply trying to stay alive and hope for a modicum of marginal family life. This burden, in addition to poor local support, was because of; 1) the increase in the population locally, 2) the increase in population of the University of Florida, both student and faculty, and 3) the increase in the population of Florida. This latter showed itself in this fact: U. S.

Highway 19 and U.S. Highway 41 West of Gainesville, U. S. Highway 441 through Gainesville, and U.S. Highway 301 East of Gainesville, became major North-South highways and there was a *huge* increase in the traffic going to South Florida. Gainesville had the only facility in the area—Alachua County Hospital (later Alachua General Hospital). Serious injuries from automobile accidents funnelled into this small county hospital. Similar conditions obtained in other communities in Florida, but further South, many community leaders recognized what was going on and gave much needed impetus to *improving facilities.* This was the *first* requirement before any recruitment of physicians could be carried out. The physicians tried, in self defense, to bring others and succeeded moderately, using family ties, but this was not adequate. These conditions went on from 1945, until well past 1965. Attrition by death and retirement kept our physician population almost static. In general the entire medical community (physicians, nurses, administrators, and *all* health-related people) were miserable and dissatisfied, as well as the public who took no blame for the local poor facilities and did not speak in terms of "our hospital," but said "your hospital," and spoke of it in pejorative terms.

While local people, medical and non-medical, were living through hard times, events as related by Dr. Barrow were moving slowly but surely. By late 1949, or early 1950, definite plans were being made and carried out. What did the medical community, "the Town", think of the medical school physicians who would be coming, "the Gown"? At first, they did not think one way or another; survival took precedence. In 1952, Dr. Russell Poor arrived and later, Dr. George Harrell, who would become the first Dean. A Faculty Medical Advisory Committee of physicians state-wide was appointed to get the physician opinion. By this time, it was apparent that a medical school would be established in Gainesville. (Essentially, Jacksonville, Miami, and Tampa cancelled each other out and Senator W. A. Shands of Gainesville took advantage of this political fact to push for the school on the campus of the University of Florida.) The physicians were much too busy to worry then about a nebulous medical school even though they had vague fears of a monolithic congregation of "medical geniuses" completely overwhelming them in Gainesville. These faceless but "perfect" physicians were feared in the aggregate. Most of the physicians, although ambivalent, could see that the advent of the medical college could be of great help eventually, even while fearing that it might also be a threat.

The Medical Sciences building was built and the first class enrolled in 1956, with Dr. Harrell as Dean, and Dr. Poor as the first Vice President.

Dr. Harrell first came with a study group and then became Dean. It fell to him to explain in advance the impact of the medical school to the local medical community and to the physicians in Florida. He was not always understood, but he did a very creditable job of this difficult task, since no one really knew what the finished product would be like. I must say that Dr. Harrell was honest and correct in his analysis and explanations; he was right almost to the letter and his thoughts expressed then are applicable to this day. He attempted to show us, the local doctors, that: 1) we would be helped, not hindered, by the new school and its influx of physicians, 2) the local community should and would have every assistance from the University of Florida in encouraging the community to provide better facilities so that there would not be any tendency to expect the medical college to take over the function of private practice, and 3) the medical school's function was teaching and that the school and the community would be complementary and not competitive. This was an idea hard to sell at first and was not apparent for years. But, he was absolutely right. The addition to Alachua General Hospital finished in 1960 was certainly partly due to his efforts. Dr. Harrell's foresight paid dividends to the University of Florida, and real fringe benefits to the local community. He and others were dedicated to getting a young faculty with great potential instead of a cadre of already well-known people relatively fixed in their ideas. As a result, many well-qualified young professors were recruited. Many of these professors are still here, having achieved recognition for themselves and the University and have been helpful and cooperative with the Gainesville physicians. We have all grown older together. These people have been good for us and, I believe their associations with local citizens and physicians have given us all a much better position in the community. Physicians in general are better understood; we certainly have a lot more clout; and almost everyone in Gainesville has a doctor for a next door neighbor!

By the time the University hospital was completed in 1958, the town physicians knew the medical school could not be ignored. Gradually, but very gradually, from 1950 to 1960, we began to get a few more physicians, but by attrition and local growth we were making very little headway. When it was generally known that the medical school was in action, some physicians were attracted, while others would not come because it was difficult to make plans for the future in Gainesville since local facilities were so poor. We were reluctant to guarantee income for prospective partners when we were not sure what would happen. Nevertheless, by 1960, true improvements and facilities and personnel were on their way, but slowly. By 1960, the total physicians (including hospital-based physicians and all specialities) were about 60; the same number present in 1965! Previously, nurses had been almost impossible to find and those who

worked in Alachua General Hospital from 1950 to 1960, or longer, were overworked and unhappy, much like the physician and other medically oriented people. However, due to the LPN training program and then the R. N. programs throughout the community colleges, the supply of nurses began to improve. By 1960, the community support was tenuous and not very strong, but from then on progress was definite, at first gradual then rapid. As Dr. Harrell had forecast, graduates of the College of Medicine and some of the teaching staff began to go into private practice in Gainesville. Each one was welcome and almost immediately became busy.

A few population figures will point up what has happened in this community. The population of Florida has risen from 2,250,000 in 1945, to an estimated 10,000,000 in 1980. The population of Alachua County has risen from 38,265 in 1945, to an estimated 145,000 in 1980. The practicing physicians have risen from 17 in 1945, to well over 150 in 1980, with an excellent mix of the various specialties and subspecialties. The clinical faculty of the College of Medicine is now over 200.

The leadership of the College of Medicine was good starting with Dr. George Harrell and his bright young men (who are now bright *older* men). However, the arrival of Dr. Chandler Stetson in 1972, as the Dean of the College of Medicine was one of the best things that ever happened to the University of Florida, and its College of Medicine. This man had it all. He had great ability, a proven record of scholarship, wisdom, and the sensitivities and humility to put it all together. The College of Medicine began to mature after his arrival. He used the personnel and the power of the medical school in a positive, purposeful way. His dealings were all honorable and fair. He died with his boots on in the service of Florida, and the University of Florida. His untimely death in 1977, at age 55, was a real loss. He left a legacy of good leadership—of the sort to guarantee good relations. Dr. Will Deal, now Dean and Vice President, was one of his proteges. Dr. Gerold Schiebler has remained active on the State scene as well as in the service of the medical school. The present leadership is "Florida oriented." Dr. Lee Dockery has been brought in from the ranks of private practice (OB-GYN) as an Associate Dean; Dr. William Ruffin well known throughout Florida, and an old time Floridian, is Chief of Staff at the Shands Teaching Hospital. There are many top-rank physicians at the College of Medicine now who qualify as true Floridians and they, and their programs, are known throughout the State as well as here in Gainesville.

It has now been 20 years since the first class graduated and there have been great changes to the good. I do not give all the credit to the medical school, but certainly some of it. Fully 60% of the physicians in practice in Gainesville now have or have had some connection with the College of Medicine. The level of competence in medical practice in Gainesville and the surrounding areas is high; the morale is high. Of my four partners in an active surgical practice, three have gone through Dr. Edward Woodward's surgical residency program at the medical school and are excellent surgeons. The same is true for other specialties, from family practice to brain and heart surgery. A family practice residency has been established under the auspices of the College of Medicine and based at Alachua General Hospital. With better facilities and much better community support now, Gainesville has become a referral center. In 1973, a second community hospital, North Florida Regional Hospital, was built. It is a real asset. In 1975, a new, modern addition was made to Alachua General Hospital. *Now*, we have two excellent community hospitals, a University Hospital (Shands), and a V. A. Hospital—a far cry from 1960, much less 1945.

Obviously there are areas where local physicians have some fears. The objectives of a medical school are different from those of practicing doctors and basic troubles can develop. The development of satellite clinics and the possibility of closed-panel groups sponsored by the Federal government are sources of worry to some. Actually, the internecine combat between the two excellent private hospitals, which spills over into their physician relations, has been more upsetting than anything the medical school has done. Those graduates and past faculty members now in practice, plus the various advisory committees, must and should see to it that good communications and fair relationships continue.

The advent of the College of Medicine of the University of Florida (and later the entire Health Center Complex) is a *plus*. After 20 years of training students and house staffs, we have reaped a boone to the citizens and physicians of Gainesville and Alachua County. The pluses have much outweighed the minuses. The "Monolithic Ivory Tower peopled by Nameless Geniuses" did not materialize. The medical school people showed themselves to be likeable human beings with the same strengths and weaknesses as the rest of us. They have given strength to the College and Shands Teaching Hospital, as a teaching and tertiary center. Lines of communication between "the Town" and "the Gown" have developed. There is mutual respect. As Dr. Harrell said so long ago, the two medical communities are complementary, not competitive. If the leadership of "the Town" and "the Gown" remains aware and fair, then things in Gainesville will continue as they are now—grand!

• Dr. Babers, 825 Northwest 23rd Avenue, Gainesville 32601.



PROGRAM

UNIVERSITY OF FLORIDA
COLLEGE OF MEDICINE
20th ANNIVERSARY REUNION
AND
SCIENTIFIC SESSIONS

MARCH 7-8, 1980

The following classes will be celebrating class reunions Saturday evening (Details on class parties are sent upon receipt of registration form):

Class of 1960—20th-Year Reunion
At the home of Mark and Mary Barrow
224 N.W. 10th Avenue

Class of 1965—15th-Year Reunion
At the home of Gerald and Marjie Hazouri
1420 N.W. 56th Terrace

Class of 1970—10th Year Reunion
At the home of Robert and Anne Slaton
6201 S.W. 36th Way

Class of 1975—5th-Year Reunion
At the home of James and Patricia Slattery
2067 N.W. 21st Lane

MEDICAL ALUMNI ASSOCIATION BOARD OF DIRECTORS 1979-80

Dr. Jean L. Bennett, Alumna 1960, Dunedin (President)
Dr. Nell Potter, Alumna 1963, Pensacola (Assistant to the President)
Dr. Orvin Jenkins, Alumnus 1968, Gainesville (Secretary-Treasurer)
Dr. Mark V. Barrow, Alumnus 1960, Gainesville
Dr. Robert A. Greenberg, Alumnus 1967, Gainesville
Dr. James E. Harrell, Alumnus 1964, Stuart
Dr. Gerald Hazouri, Alumnus 1965, Gainesville
Dr. F. Lee Howington, Alumnus 1963, Ft. Myers
Dr. John F. Nelson, Alumnus 1964, Gainesville
Dr. James Pat O'Leary, Alumnus 1967, Nashville
Dr. Steven J. Schang, Alumnus 1968, Pensacola
Dr. Robert C. Slaton, Alumnus 1970, Gainesville
Dr. Charles G. Walker, Alumnus 1965, Tampa
Dr. Steven J. Westgate, Alumnus 1980, Gainesville
Dr. Stephen R. Zellner, Alumnus 1967, Ft. Myers
Dr. William B. Deal, Gainesville
Dr. Hugh M. Hill, Gainesville
Dr. Richard Streiff, Gainesville

MEDICAL ALUMNI REUNION PLANNING COMMITTEE

Jerome H. Modell, M.D., Committee Chairman
Chairperson, Department of Anesthesiology

Dianna L. Cuppy
Director, Medical Alumni Affairs

J. Lee Dockery, M.D.
Associate Dean for Academic Affairs

Hugh M. Hill, M.D.
Associate Dean for Student and Alumni Affairs

Arthur B. Otis, Ph.D.
Chairperson, Department of Physiology

Edward R. Woodward, M.D.
Chairperson, Department of Surgery

IMPORTANT NOTES

Hotel arrangements are up to each individual.

Seminar education credits — As an organization accredited for continuing medical education, the College of Medicine at the University of Florida designates the continuing medical education activities as meeting the criteria for (5) credit hours in Category 1 of the Physician's Recognition Award of the American Medical Association.

In case of rain, the barbeque luncheon will be held in the lobby of the Dental Tower.

will be given special recognition when alumni come to Gainesville from all over the nation to celebrate the 20th anniversary of the first graduating class. Dean Harrell will be presented with an honorary Doctor of Science degree.

It is to be noted that Dean Harrell's service to health care education neither ended nor slowed down when he left UF in 1964 . . . nor has it ended since he "retired" in 1973. He departed Florida for Pennsylvania State University in 1964 where he founded the College of Medicine and became founding provost of The Milton S. Hershey Medical Center. He thus became the first administrator in the U.S. to design and develop two medical schools from the ground up. During the subsequent nine years, he directed the growth of the Hershey institution . . . again emphasizing the importance of personal human values and social and cultural environment, as equal to the scientific aspects of physician education and practice.

Now maintaining homes in Timonium, Md. and in Ponte Vedra, Fla. Dean Harrell has pursued an ever exhaustive pace in writing and consultantship work. He has served as a consultant to medical schools in Greece, Saudi Arabia, Colombia, Indonesia, Jamaica, Portugal, South Africa and Japan.

Just since retirement, his multiple services have been recognized by such awards as: the Association of American Medical Colleges' Abraham Flexner Award for Distinguished Service to Medical Education; the Society for Health and Human Values Award; and a Mastership of the American College of Physicians.

HISTORY OF THE COLLEGE

Few histories of institutions are faster paced, or richer in growth of service to people, than that of the University of Florida College of Medicine.

The impact of its operations in educating future health professionals, in caring for patients, investigating the causes of disease, providing continuing education for practitioners, and extending services to isolated populations, is felt in every part of the state. Thousands of patients referred from other states also have benefited from specialized medical services.

While the forthcoming alumni celebration will focus on the 20th year since the charter class of 40 medical doctors graduated, that is but a small part of the story. The medical college and the adjacent College of Nursing became the genesis of the J. Hillis Miller Health Center, known today as one of the nation's most complete working models of the unified approach to education of health practitioners.

"Learning together to work together," the philosophy espoused by early planners of the institution, continues to be implemented by the Health Center's six colleges, both in teaching and in numerous examples of team practice.

From an economic standpoint, the institution which sprang from establishment of the medical school has become a place of employment for more than 4,000 people and represents an investment of over $200 million in facilities alone.

In many ways, a new era of medicine was ushered in for Florida with opening of the College of Medicine. Within what was a pocket of medically underserved people, the college recruited and has sustained outstanding educators, clinical practitioners and research scientists. These faculty appointees (totaling 346 today) greatly expanded the spectrum of diagnostic and therapeutic services available to Floridians.

The opening of the medical school was soon followed by opening of the Shands Teaching Hospital which expanded so rapidly that the demand for its services has overcrowded the facilities built in 1958 and led to plans for a new patient services building. As a state referral hospital, Shands now receives more than 19,000 inpatients annually and some 222,000 outpatient visits to its affiliated clinics every year.

Today, 441 medical students are in training at UF, with 29 others enrolled in an affiliated "Program in Medical Sciences" at Florida State University and Florida A&M University. In addition, 315 residents and 52 clinical fellows are receiving training at the University of Florida Affiliated Hospitals, while 119 students pursue doctorate or master's degrees in the medical sciences. Through a separate four-year baccalaureate degree program administered by the medical college, 57 students are on their way to becoming physician's assistants.

History is made year by year as the college continues to contribute to the improvement of health care services throughout Florida and neighboring states. Major avenues of outreach services include expansion of rural health services via satellite medical and dental clinics in four communities of northcentral Florida; administration of federally funded medical services to low income women, infants and children in north and central Florida; a Health Center-based service providing computer-assisted analysis of patients' electrocardiograms from more that 20 Florida hospitals; the establishment of genetic clinics in six Florida cities; and ongoing programs of continuing education for practicing physicians statewide.

Over the past 20 years, the medical college has more than fulfilled its early commitment to increase the state's supply of highly qualified medical manpower and to make sure that all of the state's taxpaying citizens have ready access to the latest available services to treat their illnesses and to maintain good health.



J. Hillis Miller Health Center—1979

PROGRAM

FRIDAY, MARCH 7, 1980

2:30 PM — Annual Spring Meeting of the Board of Directors, University of Florida College of Medicine Alumni Association—J. Hillis Miller Health Center, Conference Room of the Vice President for Health Affairs

6:30 PM — Gala Social and Cocktail Gathering—Ballroom, Gainesville Hilton, 2900 S.W. 13th Street

8:30 PM — The John Gorrie Award Dinner—honoring founder Dr. Theodore F. Hahn (members only)—Gainesville Hilton, 2900 S.W. 13th Street

SATURDAY, MARCH 8, 1980

8:00 AM — Introductory Remarks—An Overview of the Health Center by: Dr. William Deal, Vice President for Health Affairs and Dean of the College of Medicine—Second Floor Auditorium, Chandler A. Stetson Medical Sciences Building

8:15 AM — Alumni Symposium—Moderator:
J. Patrick O'Leary, M.D., Professor of Surgery; Chief, Surgical Service, Veterans Administration Medical Center, Nashville
Alumnus—Medical School Class of 1967
Housestaff Surgery 1968-72
Academic 1972-78

8:20 AM — "Birth Defects—Whence and Whither"
Alumni Presentation by:
James G. Wilson, M.A., Ph.D., D.Sc., Professor of Research Pediatrics and Anatomy: Head, Division of Pathologic Embryology, Children's Hospital Research Foundation, University of Cincinnati College of Medicine
Alumnus—Academic, 1955-66

8:50 AM — "Computer Applications in Patient Care"
Alumni Presentation by:
Daniel E. Souder, M.D., Associate Director, Laboratory of Computer Science, Massachusetts General Hospital
Alumnus—Medical School Class of 1969
Housestaff, Internal Medicine 1969-70

9:20 AM — "Turkeys and Arteriolosclerosis"
Alumni Presentation by:
Roger F. Palmer, M.D., Professor and Chairman, Department of Pharmacology, University of Miami School of Medicine
Alumnus—Medical School Class of 1960
Academic 1963-69

9:50 AM — "Recent Advances in Reconstructive Surgery"
Alumni Presentation by:
John B. McCraw, M.D., Associate Professor and Program Director, Division of Plastic and Reconstructive Surgery, Eastern Virginia Medical School, Norfolk, Virginia
Alumnus—Housestaff, Surgery 1969-72
Academic 1972

10:20 AM — Coffee Break

10:45 AM — Recognition of Honored Guests

11:00 AM — Bestowing of Honorary Degree upon Dr. George Harrell

11:20 AM — Groundbreaking for New Hospital Construction

12:30 PM — Barbeque Luncheon—Outside on the Communicore/Chandler A. Stetson Hall Patio

2:00—5:00 PM — Departmental Seminars (Note—four scientific sessions are scheduled. The following are summaries of each session):

1)"Current Concepts in Critical Care." This program will provide an overview of problems frequently seen in critically ill patients as well as current modes of therapy used in the intensive care setting. It is designed for practitioners of multiple specialties with varying degrees of involvement in the care of the critically ill, including those who refer patients to tertiary care centers as well as those who participate in intensive care management. Room C1-9.

2)"Ethical Concerns of the Frontiers of Fetal and Perinatal Medicine." The program will focus on selected ethical issues that accompany the astounding scientific achievements now being made in fetal and perinatal medicine. The session opens with a brief introduction to ethics. Three frontiers in medical science will then be presented: a) the prevention and treatment of genetic disease; b) the application of molecular genetics; and c) the uncertainties of hormonal therapy during pregnancy. The program ends with a discussion of the ethical issues we, as doctors and humans, must face as a result of this scientific progress. Room C1-11.

3) An orthopaedic program will be presented consisting of six scientific presentations. These presentations will include discussions of problems with total knee arthroplasty, reconstruction of damaged knee ligaments, gait in patients with cerebral palsy, problems in fractures of the distal radius, and a discussion of the effect of electrical currents on bone healing. Participation and discussion by the audience is part of the program's format. Room C1-4.

4) The postgraduate seminar, "Inflammatory Disease of the Pancreas," presented by the Departments of Medicine and Surgery will evaluate recent advances in the diagnosis and medical treatment of acute and chronic pancreatitis. Newer diagnostic procedures including ultrasonography, computerized tomography and endoscopic retrograde cholangiopancreatography will be discussed. Surgical approaches to the complications of chronic pancreatitis will be presented with specific reference to longitudinal pancreatojejunostomy, pancreatic denervation, and surgery of the biliary and pancreatic sphincter. Room H-611.

FOREWORD

After twenty years, the University of Florida College of Medicine has entered the exciting period of young adulthood. Clearly, the tripod foundation of a high quality medical school is firmly entrenched: education, research and service. Our founders were visionaries who foresaw a medical school-teaching hospital partnership and would be pleased by its growth and development. The J. Hillis Miller Health Center has evolved into six colleges and three hospitals which broaden our education, research and service opportunities. Now the College of Medicine is in a unique position to meet the future challenges with enthusiasm and vigor.

Thanks to the faculty, students, staff, alumni, friends and my predecessors for fostering this institution through the previous years. With our concerted effort, the University of Florida College of Medicine will continue to be a national resource.

The future is bright and quality improvement will be the guiding principle.

William B. Deal, M.D.



Dr. William Deal
Dean, College of Medicine and
Vice President for Health Affairs



DR. GEORGE HARRELL— FOUNDING DEAN

"The practice of medicine will forever remain an art and can never be a science. For this reason, both the preprofessional and the professional training should emphasize more of the art of understanding and handling people."

Espousing such personal philosophy, Dr. George T. Harrell, Jr. worked long and diligently to establish the University of Florida College of Medicine . . . charting its long-range direction, formulating its goals, and aiding the design of a physical plant that would reflect the school's philosophy.

As founding dean, Dr. Harrell stayed with the College of Medicine through its first decade of life, steering its expansion as a vital resource of health care service, education and research for the entire Southeast. Harrell has been described by friends and colleagues across the country as a strong, effective planner and leader . . . a man who by virtue of more than 42 years of continuous work has gained an international reputation for designing bold innovations in both curriculum and physical facilities for medical education, research and patient care.

Dr. Harrell's gift of service, although primarily to the medical college, extended also to development of the entire J. Hillis Miller Health Center. He moved to Gainesville in the early 1950's (from Bowman Gray School of Medicine), joining the late Dr. Miller and Dr. Russell S. Poor, the first provost, in laying the groundwork for the Health Center. He helped seek the initial state appropriation of $5 million for construction of buildings for both the Colleges of Medicine and Nursing.

These and many other specific contributions by Dr. Harrell as the College of Medicine's leading forefather,

Origin and Development of University of Florida College of Medicine

Mark V. Barrow, M.D., Ph.D., and Chandler A. Stetson, M.D.

The University of Florida College of Medicine, begun in the early 1950's and completed in 1956, graduated its first class in 1960. The first state medical school in Florida continues to grow and expand. It, therefore, seems appropriate to review the history of this medical school at intervals. The last review which considered the initial phases of development was published in this Journal in August 1968.[1]

Florida's educational history dates back to the mid-19th century when the new state established two seminaries which later became state universities, one in Tallahassee and the other in Gainesville. During World War II, Dr. John J. Tigert recognized the need for a medical school in the University of Florida and also urged that it be at Gainesville because of the central location and benefits to be derived from an affiliation with the existing University. In 1943 the State Legislature recommended establishment of a school of medicine, dentistry and pharmacy in Florida but did not provide funds or stipulate a specific location. This recommendation was not implemented and Florida continued to obtain its physicians from outside the state. Students from Florida who desired to obtain an M. D. degree were sent to several universities including Duke, Emory, Tulane and Vanderbilt. The Florida legislature's subsidy provided $1,500 per year for the education of each of 55 students.

When Dr. J. Hillis Miller became the fourth president of the University in 1947, he envisioned a large health center complex in his inaugural address. Because of his interest and a citizen committee's recommendations and an unfavorable ratio of one doctor to 1,100 citizens, the Legislature authorized a survey of health services in Florida to study the needs and location and cost of a medical school. This study was undertaken by Vernon W. Lippard, then Dean of the School of Medicine at Louisiana State University, and was completed in 1949. As the result of this report, in April 1949 the State Legislature authorized the creation and establishment of a medical school and nursing school at the University of Florida, but again no monies were appropriated. Another study headed by Dr. Lippard resulted in appropriate recommendations toward financing the building of the medical school. By 1951 the legislature had appropriated monies for assisting the first medical school in Florida at the University of Miami. A year later, in July 1952, Dr. Russell S. Poor was selected as director of a medical center study and, with a committee consisting of 15 Florida practitioners of medicine, outlined the status of Florida physicians in the 1950's, described the health needs of the people of Florida, discussed Florida's hospitals and nurses and provided a resume of the university programs related to medical education.

In April 1953, the Legislature appropriated $5 million for the building of a medical sciences building, to house colleges of medicine and nursing on the campus of the University of Florida with the recommendation that the already functioning College of Pharmacy and Cancer Research Laboratory be integrated into this unit at a later time. Dr. Russell S. Poor was selected as provost for the Health Center, and Dr. George T. Harrell, who had also been on the committee for the Health Center study, was selected as the first Dean of the College of Medicine.

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CHANDLER A. STETSON, M. D.

The late Dr. Stetson was Vice President of the University of Florida for Health Affairs and Dean of the College of Medicine at the time of his death in 1977.



Dr. Barrow

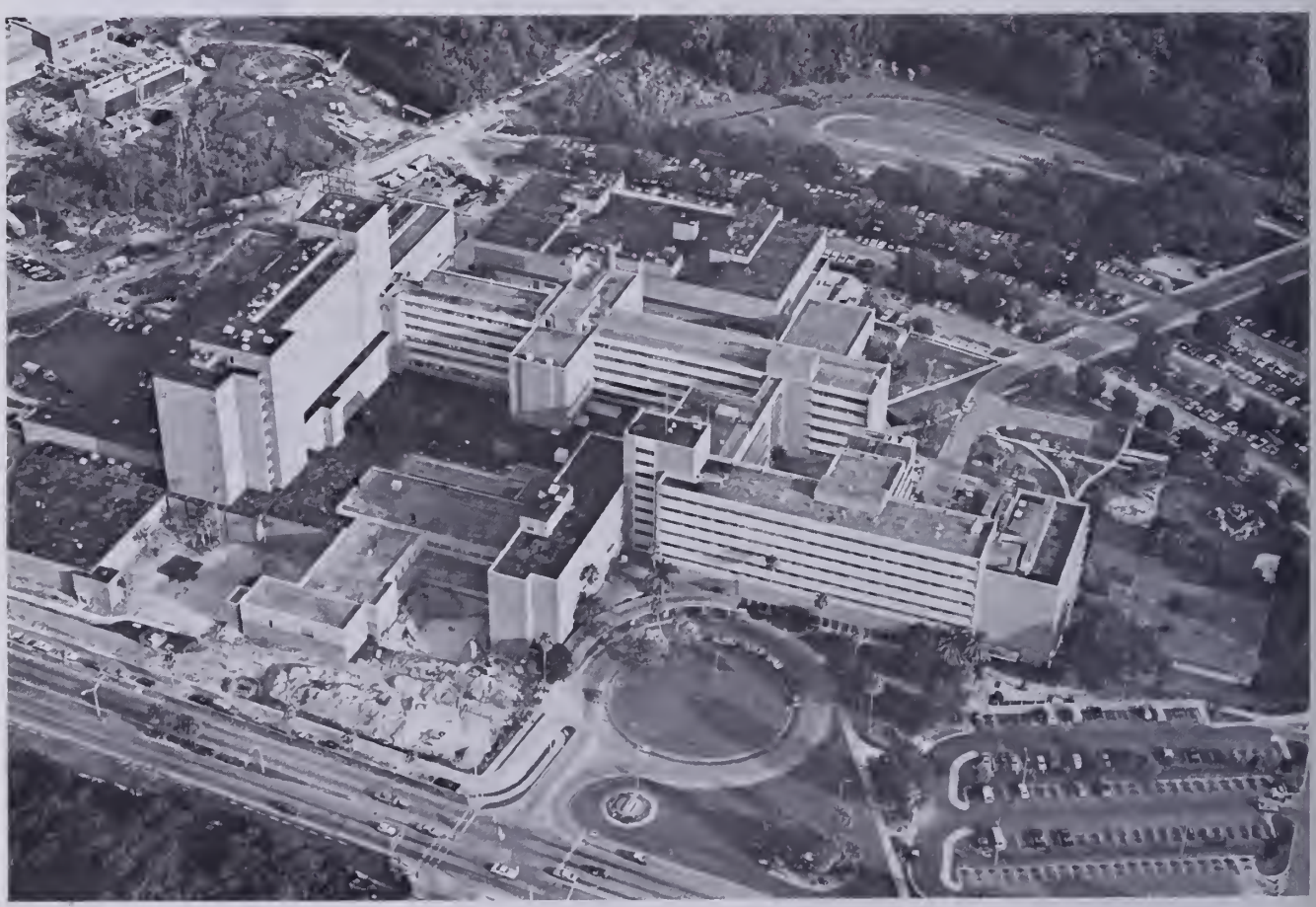
This article, written with Dr. Stetson, then Dean of the University of Florida College of Medicine, was previously printed in the January, 1974, issue of *The Journal of The Florida Medical Association.*

In late fall 1954, the actual construction of the Medical Sciences Building was begun. A year later, in April 1955, the Legislature approved $8.6 million for construction of the teaching hospital which was to join the Medical Sciences Building, thereby insuring the establishment of the second phase of the development of the Medical Center.

The Medical Sciences Building was completed in the fall of 1956, barely in time for the first medical class of 48 students. The cost of the 238,000 square foot building was $5.4 million. A group of key department chairmen was selected and the school began its active education of physicians for the state of Florida. In October 1958 the teaching hospital was completed and opened at a total cost of $9.8 million for its 375,000 square feet. The teaching hospital, the clinics and ambulant wing consisted of seven floors with a connecting section between the hospital and the Medical Sciences Building. By 1959, the Florida Legislature had appropriated $1.4 million which, together with matching federal funds, provided for construction of a pharmacy wing on the western end of the Medical Sciences Building, thus allowing the College of Pharmacy to be integrated with the Medical Sciences Building and combining under one roof the Colleges of Medicine, Nursing, Health Related Professions and Pharmacy.

Thus from the time that clear need was demonstrated for a medical school in Florida as indicated by the Florida Legislature action in 1943, there was a 13-year delay before this school was completed and a 17-year delay before the first medical class was graduated. It is important to note that the major part of the plan for the Health Center in the early stages at least was by nonmedical people. Careful emphasis on preplanning and study of the problems involved in the setting of realistic goals made for a much smoother development program in later years while studied selection of key personnel and initial chairmanship appointments undoubtedly influenced the rapid procurement of faculty which followed.

The College of Medicine was fully accredited by the American Medical Association and the Association of American Medical Colleges in the spring of 1960, and on June 6, 1960, the College graduated its first class of 40 students. The stage was now set for a period of rapid growth and development. Under Dr. Harrell's leadership,



University of Florida College of Medicine

the faculty grew in stature and in numbers, and both private and public funds were provided in abundance to assist the young school in developing its educational, patient-care and research programs. In 1962 the Clinical Research Center was established with a grant of over $2 million from the National Institutes of Health, and the Eye Clinic was opened as a valuable new clinical and teaching resource for the State. Dr. Poor resigned his position as Provost to become Director of Nuclear Education and Training with the Atomic Energy Commission in 1962, and was replaced by Dr. Samuel P. Martin. In 1964 Dr. Harrell resigned as Dean to preside over the creation of another new school of medicine in Hershey, Pennsylvania and Dr. Emanuel Suter was selected as the School's second dean. In August, 1965 a federal grant was awarded to support the new Center for Neurobiological Sciences which has come to be a major strength in the teaching and research programs of the College. Also in 1965, construction was started on the Human Development Center and the Child Psychiatry Unit, supported by funds appropriated by the State Legislature and matched by a grant from the Health Research Facilities Branch of the National Institutes of Health.

A major development in the life of the College of Medicine was the founding of the Veteran's Administration Hospital just across Archer Road. Mr. J. Malcom Randall was appointed director in 1966, and the hospital was activated in 1967. This 480-bed hospital has been, since its inception, closely affiliated with the College and the relationship has been a model of cooperative endeavor. Teaching programs of the College of Medicine have been much strengthened by this resource, while patient care at the Veteran's Administration Hospital has been superb because of the participation of College faculty. The year 1967 also saw the development of a close relationship between the College of Medicine and JHEP (Jacksonville Hospitals Educational Program). This relationship was formalized in 1969 by an action of the Board of Regents which in effect made JHEP a division of the J. Hillis Miller Health Center. Under this agreement the University of Florida is responsible for graduate medical education and for continuing medical education programs in the participating hospitals in Jacksonville, an arrangement which greatly benefits both parties and strengthens their programs. In the same year, the library of the Health Center became a participant in the MEDLARS program of the National Library of Medicine, thus acquiring access to a computerized information retrieval system of value to students and teachers alike.

During the 1960's much emphasis was placed on the development of maternal and infant care programs in the Department of Obstetrics and Gynecology. In 1966 the Florida State Board of Health made a grant to the Department for a Maternal and Newborn Care project aimed at providing prenatal and postnatal care to mothers and newborns in rural areas of 13 North Florida counties. This and related programs attracted national recognition and provided a strong base for the obstetrical and pediatric teaching programs of the College. In 1967 Mrs. Cordelia Seaife May made a gift of $600,000 to establish the first endowed chair in the history of the University of Florida and this chair was named for former President J. Wayne Reitz. Subsequently two additional endowed chairs have been created in this department to support work in the general areas of developmental and reproductive biology and of family planning.

Another change in leadership occurred in 1967. Dr. Samuel P. Martin stepped down as Provost of the Health Center and was replaced, in 1969, by Dr. Edmund F. Ackell. At about the same time the Board of Regents had approved a $30 million building expansion program and Dr. Ackell shepherded this largest of all University of Florida projects through difficult times to its present happy fruition. Nearly $20 million in federal funding was secured, remaining funds were allocated by the State in 1969, and bids were opened in January 1971. Unexpectedly high construction costs forced some cutbacks in the project, but groundbreaking took place in May 1971 and the first elements of the project are being finished as this is being written. The finished project will have nearly doubled the space available in the Health Center; will have provided full teaching, research and clinical facilities for the new College of Dentistry; will have provided unmatched study and teaching facilities for students of the College of Medicine, and will have provided for necessary expansion of the library and of other elements of the Health Center including the College of Nursing and the College of Health Related Professions.

Another milestone in the development of the College of Medicine was creation of the Department of Community Health and Family Medicine. Begun in 1968 as a division within the Department of Medicine, the new unit was dedicated to the training of family physicians and quickly received enthusiastic acceptance and support. It acquired departmental status by Board of Regents action in 1971 and has many achievements to its credit in its short life: development of a model rural health clinic in the town of Mayo where 1,000 citizens and 2,000 rural neighbors had been without a doctor for ten years; development of the State's first physician's assistant training program in cooperation with Santa Fe Community College; and establishment of three model family practice residency programs in Gainesville, Tallahassee and Jacksonville. Also begun in 1968 was an imaginative and effective program under which electrocardiograms are telephoned in to the Health Center from communities throughout North Florida and immediately processed

and interpreted by computer. Checked by experienced cardiologists, this service continues to be of real benefit to physicians and patients alike, and represents a particularly successful effort on the part of the College of Medicine to serve as a resource for physicians throughout the State.

The year 1969 saw the inauguration by students of the annual Hippocratic Award for Teaching Excellence which has already become a traditional spring event; commencement of an inservice continuing education program for Florida physicians; and the opening of the Tumor Biology Laboratory which has already gained an international reputation for research in the field of tumor immunology and tumor viruses. Shortly thereafter, a three-year planning effort resulted in the opening of the Pediatric Intensive Care Unit to give the sophisticated care demanded by rapid advances in pediatrics and surgery. The State's first live kidney transplant was performed here in 1970, and an active renal transplantation program has been developing ever since together with a renal dialysis program.

Pursuing its objectives of cooperating with community groups for furthering graduate medical education, the College entered in 1970 into a academic affiliation with PEP (Pensacola Educational Program) providing for strengthening the house staff and continuing education programs of several hospitals in that city. At about the same time, the College entered into an arrangement with Florida State University and with Florida A & M University, under which students at the latter universities enroll in the Program in Medical Science (PIMS) at Tallahassee, receiving most of their preclinical medical education prior to graduation from college. This enables those students to enter the College of Medicine at the University of Florida with advanced standing, with an opportunity to obtain the M. D. degree seven or even six years after leaving high school. The first students from PIMS arrived at the College of Medicine in September 1972. Approximately 30 PIMS students have joined our students each fall since 1974. The graduating classes from this College of Medicine, which have averaged about 60 students each, will now increase in size due partly to the students transferring from PIMS and partly to an increased number of students being admitted to our first year classes.

From its inception the College of Medicine was designed to be part of an academic health center, rather than a free-standing medical school. Master planning provided for housing all components of the Health Center under a single roof, facilitating interaction between the staffs and students of the several colleges. The College of Nursing was begun in 1956; College of Health Related Services was founded in 1958 and renamed the College of Health Related Professions in 1964; College of Dentistry admitted its first class in 1972; and the College of Veterinary Medicine is still in its planning stages. The College of Pharmacy moved into the Health Center in 1961. These Colleges together with the Shands Teaching Hospital and Clinics made up the J. Hillis Miller Health Center, which has served as a model for the development of academic health centers around the nation. Students in all these colleges are "learning together to work together" in the health team concept, an idea which has survived all the difficulties inherent in the stepwise and sequential development of the units.

The objectives of the College of Medicine continue to be (a) to furnish the best possible medical education to each of our students whatever his or her career goals may be; (b) to help in providing for the people of this state a unique and sophisticated referral center with diagnostic and treatment facilities beyond those which can be supported in community hospitals; (c) to cooperate with the Florida Medical Association, county medical societies and community physicians in providing various modalities of graduate and continuing medical education for Florida's physicians, and (d) to conduct research programs which range from basic research to studies of health care delivery systems. Emphasis in recent years has been on trying to help solve Florida's needs for more medical manpower in the area of primary care and family practice, through changes in undergraduate curriculum and development of family practice residencies and rural health care programs. A recent curriculum reorganization has provided for an integrated basic science teaching program and for more elective time to permit each student to have in-depth experience in areas of his own choice. The youth and relatively small size of the College have been positive factors in attracting able students and teachers alike, since there has been ample opportunity for close student-teacher relationships. The College has been blessed from its beginning with able leadership and with the far-sighted support of countless dedicated and public-spirited citizens. With all the uncertainties in these troubled times for medicine and medical education, the College looks forward with good hopes and clear prospects of fulfilling its destiny as a premiere institution of the State and the region.

Reference

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• Dr. Barrow, 1130 Northwest 64th Terrace, Gainesville 32601.

The University of Florida College of Medicine's Alumni During the School's First Twenty Years

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The University of Florida College of Medicine in May of 1980 will graduate 116 physicians, nearly three times the forty graduates in the first class of 1960. The total number of physicians to receive their M.D. degree will swell to 1,409 for the 21 year effort.

For purposes of this report, only the data of the 1,293 men and women receiving their M.D. degree from the classes of 1960-1979 will be analyzed. Postgraduate trainees are not included. Also the data from the graduating classes 1975-1979 will additionally be separated because many of these alumni are still in internship and residency training.

The data on the 1,293 University of Florida medical alumni is presented in the following categories:

1) Medical student admission to the College of Medicine by in-state, out-of-state, and Florida county distribution.
2) The internship and residency distribution of alumni by state and Florida county.
3) The medical practice distribution by state and Florida county distribution.
4) Specialty distribution.

Through the diligence of the Office of Medical Alumni Affairs, and with the cooperation of the Alumni, the address and activity are known on every M.D. graduate.

Medical Student Admissions

Of the 1,293 graduated physicians, 1,149 were Florida residents at the time of their entry to the College of Medicine. The out-of-state residents at the time of admission totaled 144. (Table I)

Table 1

UNIVERSITY OF FLORIDA
COLLEGE OF MEDICINE ALUMNI

1960-1979

FLORIDA RESIDENCY STATUS UPON ADMISSION

Out of State	144
Florida Residents	1,149
Total Number Graduates	1,293

Florida County Categories

Florida counties were categorized by population size, on the basis of their population in 1960. To determine the applicability of these 1960 statistics for the complete time range with which this study deals, Pearson product moment correlation coefficients were run comparing the 1960 population figures with the 1950 and 1975 figures. The correlation of county size from 1950 to 1960 was .975; the correlation of county size from 1960 to 1975 was .974. These high, almost perfect correlations, indicate that all the counties changed in size through the twenty-year period, but they basically maintained the same ranks through the years in relationship to one another. Counties which had the smallest population in 1950 tended to be the smallest in 1960 and 1975. These strong relationships justify the categorization of Florida counties according to their population size in 1960. Five categories based on the 1960 census statistics were established:

1) Counties over 85,000 in population.
2) Counties having from 60,001 to 85,000 in population.
3) Counties having from 35,001 to 60,000 in population.
4) Counties having from 10,001 to 35,000 in population.
5) Counties under 10,001 in population.

Florida Counties of Residence of Alumni Upon Entry to the University of Florida College of Medicine

In Table 2 it is shown that 1,149 alumni of the total of 1,293 alumni (through 1979) were Florida residents at the time of their entry into the University of Florida College of Medicine. The distribution by county of these 1,149 is presented in Table 2. The counties are categorized according to the 1960 population figures and presented according to their rank and population size. A rank order by population is used. Fifty-nine of the 67 Florida counties are represented in this distribution.

Counties were also ranked in terms of number of alumni who were county residents upon entry to the University of Florida College of Medicine. These ranks determined by alumni number, appear as tied ranks when the frequency of alumni is the same for more than one county.

Table 2

DISTRIBUTION OF ALUMNI ACCORDING TO FLORIDA COUNTIES OF RESIDENCE UPON ENTRY TO UNIVERSITY OF FLORIDA COLLEGE OF MEDICINE

County	Rank in Population Size-1960	Rank in Alumni Numbers	Number of Alumni	% of Total Alumni
Cateogry 1: Counties over 85,000 in population				
Dade	1	1	178	15.5
Duval	2	2	127	11.1
Hillsborough	3	6	69	6.0
Pinellas	4	5	86	7.5
Broward	5	4	74	6.4
Orange	6	7	68	5.9
Palm Beach	7	8	53	4.6
Polk	8	10	40	3.5
Escambia	9	12	30	2.6
Volusia	10	11	34	3.0
Brevard	11	13	24	2.1
TOTAL			783	68.2
Category 2: Counties 60,001-85,000 in population				
Sarasota	12	14	18	1.6
Leon	13	9	49	4.3
Alachua	14	3	121	10.5
Manatee	15	17	11	1.0
Bay	16	20	7	0.6
Okaloosa	17	19	8	0.7
TOTAL			214	18.7
Category 3: Counties 35,001-60,000 in population				
Lake	18	22	5	0.4
Seminole	19	21	6	0.5
Lee	20	15	14	1.2
Marion	21	15	14	1.2
Monroe	22	25	2	0.2
Gadsden	23	22	5	0.4
St. Lucie	24	21	6	0.5
Pasco	25	25	2	0.2
Jackson	26	10	10	0.9
TOTAL			64	5.5
Category 4: Counties 10,001-35,000 in population				
Putnam	27	23	4	0.3
St. Johns	28	16	12	1.0
Santa Rosa	29	25	2	0.2
Indian River	30	18	9	0.8
Highlands	31	26	1	0.1
Columbia	32	20	7	0.6
Clay	33	24	3	0.26
Osceola	34	23	4	0.3
Nassau	35	26	2	0.2
Martin	36		0	
Collier	37	22	4	0.3
Walton	38	27	1	0.1
Suwannee	39	23	4	0.3
Charlotte	40	25	4	0.3
Bradford	41	23	4	0.3
Taylor	42	27	1	0.1
Sumter	43	26	1	0.1
DeSoto	44	26	1	0.1
Hernando	45	26	1	0.1
Washington	46	26	1	0.1
Holmes	47	24	3	0.26
Levy	48	26	1	0.1
Gulf	49	26	1	0.1
TOTAL			71	6.0
Category 5: Counties Under 10,000 in population				
Citrus	50	24	3	0.26
Jefferson	51	25	2	0.2
Hendry	52	26	1	0.1
Calhoun	53	23	4	0.3
Baker	54	25	2	0.2
Okeechobee	55	26	1	0.1
Wakulla	56	26	1	0.1
Dixie	57	26	1	0.1
Flagler	58	26	1	0.1
Lafayette	59	26	1	0.1
TOTAL			17	1.6
GRAND TOTAL			1,149	100.0

In Table 2, the first entry demonstrates that Dade County was given a population rank of one, and a rank of one for alumni number (e.g. Dade county was number one in county population and alumni number). Of the 1,149 alumni who were Florida residents, 178 (or 15.5%) were residents of Dade County. This percentage is very consistent with Dade county's population of 1,437,900 (1975), which is 17% of the entire state's population. Legal residents from counties near the University of Florida College of Medicine, University of South Florida College of Medicine, and the University of Miami School of Medicine tend to enroll in these institutions because of legal Florida residence status obtained during their pre-medical education.

The magnitude of statistical correlation indicates that the relationship between county size and county number of alumni is high and positive. In general, counties are contributing alumni in numbers proportional to their relative population size. Discrepancy between the two assigned ranks may be well related to the geographical location of counties, and their proximity to other medical schools.

Alachua County is the third county of number, with 121 residents upon entry into medical school. Since the University of Florida undergraduate campus is also in Alachua County, this correlation is correct and expected because of the high number of applicants to the College of Medicine, who also attend the University of Florida as undergraduates. A summary of the information presented in Table 2 for the 1,149 alumni who were Florida residents at the time of entry to the University of Florida College of Medicine is as follows:

1) 783 were residents of counties over 85,000 in population.

2) 214 were residents of counties 60,001 to 85,000.

3) 64 were residents of counties 35,001 to 60,000.

4) 71 were residents of counties 10,001 to 35,000.

5) 17 were residents of counties under 10,001 in population.

The resident county of all Florida alumni was identified.

The data indicate that 68.2% of the alumni group were residents of Category 1 counties (Table 2) at the time of their entry into medical school. The other 48 smaller counties from which alumni came accounted for another 31.8% of the Florida resident alumni group.

County of Residence and Location Of Private Practice

The alumni's county of residence at the time of entry into the University of Florida College of Medicine was examined with reference to the geographic location of their offices in private practice or academic medicine. Nearly fifty-seven percent of the 1,293 alumni established offices in the United States at the time data were compiled in the fall of 1979, and the location of their practices was recorded. It should be recognized that many alumni of the classes of 1975 through 1979 are still in their postgraduate educational programs, and/or Armed Forces at the time of the data compilation. The opportunity to establish practice or academic careers has not yet been realized. This factor accounts for what may seem to be an excessively small percentage of alumni in private practice and academic medicine.

The classification of alumni by Florida county of residence and location of their offices or practices are presented in Table 3. Of those alumni who have established practice, 83% are in private practice as opposed to 17% who have chosen academic medicine.

Table 3

UNIVERSITY OF FLORIDA COLLEGE OF MEDICINE

1960-1979

PRACTICE ACTIVITY

Number Deceased		10
Number Inactive		9
In Practice (Private)		
Within Florida	335	
Outside Florida	267	
Subtotal		602
In Practice (Academic Medicine)		
Within Florida	38	
Outside Florida	93	
Subtotal		131
U.S. Public Health Service		
Within Florida	3	
Outside Florida	14	
Subtotal		17
In Armed Services		81
In Training		
Within Florida	117	
Outside Florida	326	
Subtotal		443
TOTAL NUMBER GRADUATED		1,293

In table 3 it is also noted that 55.6% of the 602 in private practice are practicing in Florida. Thirty-four percent of the total number of 1,293 alumni are still in training. If alumni in the U.S. Public Health Service (17), the Armed Forces (81), deceased (10), and inactive (9), are removed from the total of 1,293 alumni, 507 are in the State of Florida, either in private practice, academic medicine, or in training. Of the 686 outside Florida, 47.5% are still in training.

The number of Florida residents upon admission to the College of Medicine is correlated in Table 4, categorized by county. The establishment of practice in counties having the largest population has almost the same percentage as the entry to medical school. As can be seen in Table 4, a large majority of Florida practicing alumni established practices in counties in the same category size as those in which they originally resided. There is a mild redistribution from the two larger county groups to the counties with 35,001 to 60,000 population. The total impact will not be determined until the 443 alumni in training have established themselves.

Table 4

DISTRIBUTION OF ALUMNI BY FLORIDA COUNTY OF RESIDENCE UPON ENTRY TO UNIVERSITY OF FLORIDA COLLEGE OF MEDICINE AND LATER PRACTICE ACTIVITY

Population	Number Admitted	Location of Practice Activity (Includes Academic Medicine)	
Over 85,000	783	194	(52.0%)
60,001-85,000	214	105	(28.1%)
35,001-60,000	64	38	(10.2%)
10,001-35,000	71	35	(9.4%)
Under 10,000	17	1	(0.3%)
TOTAL	1,149	373	(100.0%)

Table 5

Medical Alumni by Location Outside of Florida

State or Country	Priv Prac	Acad Med	UPHS/ VA	Training	Total	State or Country	Priv Prac	Acad Med	UPHS/ VA	Training	Total
Alabama	9	4		20	33	Nebraska		1			1
Arizona	4	1	1	5	11	Nevada	1	1			2
Arkansas	4	1			5	New Jersey		1			1
California	33	9	7	44	93	New Mexico			1	1	2
Colorado	6	1		7	14	New York	8	4		7	19
Connecticut	6	2		11	19	No. Carolina	33	10	1	44	88
Delaware				1	1	Ohio	6	2		8	16
Dist. Columbia		1		3	4	Oklahoma	4			1	5
Georgia	27	6	1	9	43	Oregon	3	1		4	8
Hawaii	4	1			5	Pennsylvania	6	3		8	17
Idaho	4				4	Rhode Island	1			2	3
Illinois	5	1		3	9	So. Carolina	9	4		8	21
Indiana	3	2			5	So. Dakota	1				1
Iowa	2			2	4	Tennessee	8	4		16	28
Kentucky	2	1		7	10	Texas	18	6		25	49
Louisiana	3	1		12	16	Utah	8	3		8	19
Maine	3			2	5	Vermont	1			3	4
Maryland	4	6	1	16	27	Virginia	19	2		16	37
Massachusetts	6	4		7	17	Washington	4	1	1	3	9
Michigan	2	2		6	10	W. Virginia		2	1	3	6
Minnesota	1	2		1	4	Wisconsin	1	2			3
Mississippi				1	1	Wyoming	2				2
Missouri	1	1		11	13	So. America	1				1
Montana	4				4	Israel				1	1
						TOTALS	267	93	14	326	700

Table 6

MEDICAL TYPE CATEGORIES OF 1,274 ALUMNI

SPECIALTY	TOTAL
Medicine	312
Family or General Practice	142
Pediatrics	126
Surgery	108
Radiology	99
Obstetrics & Gynecology	90
Psychiatry	72
Orthopaedics	55
Pathology	50
Anesthesiology	47
Emergency Room Medicine	43
Ophthalmology	40
Neurology	25
Dermatology	21
Otorhinolaryngology	19
Urology	18
Pharmacology	3
Allergy	2
Adolescent Medicine	1
Nutrition	1
TOTAL	1,274

Alumni Out-Of-State

The out-of-state alumni are presented in Table 5 by state and practice activity; 326 of out-of-state alumni are still in training. Geographically, the largest number of alumni in practice (includes academic medicine) and in training are located in the southeastern part of the United States. North Carolina and California have the highest number of alumni out-of-state, with 88 and 93 respectively.

Medical Specialty

Medical specialty by which residencies and private practice were identified was classified according to two categories: primary care and other. For purposes of this report, primary care is defined as family medicine, general practice, internal medicine and pediatrics. The components of "other" care are not listed in tabular form. Although traditionally considered in the category of primary care, obstetrics and gynecology was classified under "other". Twenty-one specialties are represented in the career choices of the 1,274 alumni, excluding those 19 alumni who are deceased or inactive. In Table 6, internal medicine is noted to continually outnumber the other specialties. Obstetrics and gynecology has doubled in number for the last three years, with a total of 90 alumni. Of the 1,274 alumni, 573 or 45% have chosen primary care fields, and 55% are other specialty care.

Summary

In the analysis of the professional activities of the alumni during the first 20 years of the University of Florida College of Medicine, several important points need to be emphasized. The College of Medicine serves the State of Florida well, in that an overwhelming percentage of alumni were Florida residents (87.5%) at the time of entry into the College of Medicine. It is encouraging to note that 31.8% of the alumni were from Florida counties below 60,000 in population. Of those alumni who have established practice in Florida, 20% have returned to counties below 60,000 in population, but 443 alumni in training have yet to define their practice location. Of importance is that of the practicing physicians, 45% are primary care physicians, and if obstetrics and gynecology were included in this figure, the primary care effort would increase to 52%.

It is clear that the initial investments and the continuing support of the State of Florida have paid dividends in the education of physicians who can and have significantly improved medical care available to **all** the citizens of Florida. The added impact upon the state of the more than 1,265 physicians who have received all or part of their specialty training at the College of Medicine (not included in this paper) further emphasizes the positive role of the College of Medicine upon the health care in the State of Florida.

Life is not easy for any of us. But what of that? We must have perseverance and, above all, confidence in ourselves. We must believe that we are gifted for something, and that this thing, at whatever cost, must be attained.

Marie Curie

Highlights of Twenty Years' Research at the University of Florida College of Medicine

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Research, woven into almost every aspect of clinical practice at the University of Florida College of Medicine, has contributed immeasurably to the institution's evolvement as a major state resource for innovations in diagnosis and treatment.

Some therapeutic advances resulting from UF research have become widely adopted standard therapy by now. For example, the development of cryopreservation for long-term storage of corneal tissue prior to keratoplasty made nationwide news in 1966 and 1967. By the early 1970's, there emerged from the same UF research laboratories a new liquid medium (named the M-K Media) for storage of donor corneas under ordinary refrigeration. Eye banks throughout the world have adopted the use of this relatively inexpensive liquid preservative.

Through similar pioneering research, a UF pharmacology professor developed and introduced a new class of sulfonamide drugs which inhibit the action of carbonic anhydrase (an enzyme) and thereby diminish the production and flow of body fluids. Continued investigation of these drugs has led to their effective use in treating glaucoma, certain cases of hydrocephalus, and some neurological disorders. The specific drugs which emerged from this research are acetazolamide and methazolamide.

Recent advances continue to make the UF Health Center a pacesetter. To name a few: the current investigation of a new battery-powered pump which provides continuous insulin infusion for treatment of children with brittle diabetes mellitus; the successful testing of a new vaccine used to desensitize persons who are allergic to the fire ant sting; new uses of endoscopic instruments as alternatives to major surgery in several aspects of diagnosis and treatment; and the introduction of new microneurosurgical procedures for bypassing obstructed cerebral arteries in an effort to prevent major stroke, and for the safe removal of tumors inside the brain and spinal cord.

Surgeons in the Department of Obstetrics and Gynecology also are among first in Florida to surgically reconnect fallopian tubes which previously had been tied



Fig. 1. — Children with congenital cataracts are undergoing early surgery and early visual corrective measures at the University of Florida's Shands Teaching Hospital. UF ophthalmologists believe that the chances for restoring binocular vision may be greater if corrective measures are taken while the infant's visual system is in critical stages of development.

or clamped to prevent conception. Several women have given birth to healthy babies as a result of these microsurgical operations.

In other clinical research during the past five years, the implantation of new corneal prostheses (tiny optical cylinders which duplicate the function of a patient's natural cornea and lens) has restored sight to more than a dozen formerly blind persons. Recently, the researchers switched from the former use of prostheses made of teflon and methacrylate to a new biocompatible ceramic material which is said to be optically superior and more durable than the plastics.

Among recent recipients of the optical cylinder was a woman who had been totally blind for 20 years. Two weeks after surgery at the UF Shands Teaching Hospital, she returned to her home in St. Louis, Missouri, with the ability to read large print and to see her grandchildren for the first time.

Through ongoing basic science research, UF faculty members are clarifying specific ways in which alcohol damages nerve cells in the brains of rats; gaining new insights into the mechanism by which elevated levels of high density lipoprotein (HDL) is associated with a low incidence of coronary artery disease; studying the biochemical and metabolic fate of cancer-causing chemicals and other pollutants in common species of marine life; and entering new avenues of DNA recombinant studies which, among other things, may expand knowledge of what happens to living cells during the aging process.

The College of Medicine's lifespan of 20 years has been long enough to see many research enterprises jump that important gap between the exploration of promising ideas and direct benefit of patients. A recent example was a ten-year-old Jacksonville boy with a large pleomorphic adenoma (a rare mixed tumor of the minor salivary gland) deep within the trachea. Whereas the standard approach would have been major thoracic surgery, a UF pediatric surgery team employed a cryosurgical technique which had been carefully evaluated in animal models during the previous year. Following tracheostomy, a bronchoscope was inserted for visualization of the trachea and a miniaturized cryoprobe was passed through the bronchoscope. The tumor was frozen during four brief procedures, then removed (bloodlessly) with biopsy forceps. A year later, biopsies of the trachea revealed no signs of recurrent tumor.

More than three years ago, UF pediatricians reported several successes in the use of cryosurgery to eradicate scar tissue which had formed in the windpipes of children following long-term intubation or tracheostomies. The physicians said cryosurgical treatment for scarred and narrowed tracheas is fast, safe and effective, with little additional scar formation resulting from the treatment itself. As in the former case, this new clinical application was preceded by extensive investigation in animals.

Interestingly, almost 14 years ago, another UF physician in the Department of Ophthalmology initiated use of the cryoprobe as an aid to the eradication of retinoblastomas in children. The same treatment now is used widely across the country in treatment of this rare malignant tumor, often in conjunction with radiation therapy.

The common brain disorder, epilepsy, is another example of a problem that is being treated more effectively today because of advances in research.

Data from drug studies at UF and at the VA Medical Center became important to the Food and Drug Administration's 1978 decision to approve the drug Sodium Valproate for treatment of petit mal and mixed seizures.

In a clinical follow-up to extensive research, UF faculty members in the Division of Neurosurgery have helped selected patients achieve their first relief from seizures following surgical removal of the epileptic focus. Results, to date, indicate that such cortical excisional therapy is highly effective for patients with severe focal epilepsy who were non-responsive to standard or investigational drug therapy. It has been emphasized that it takes an institutional commitment to accomplish safely



Fig. 2. — The Regional Computerized Electrocardiogram Processing Center operated out of the Shands Teaching Hospital now benefits 25 Florida hospitals. The center was expanded and improved last year, thanks to a contribution by Mr. and Mrs. M. M. Parrish of Gainesville (couple in center above). Touring the facility with the Parrishes, following dedication of the new center, are Dr. William Deal, Vice President for Health Affairs and Dean of the College of Medicine; Dr. Lamar Crevasse Jr., professor of medicine (specializing in cardiology); and at far right, Dr. Mario Ariet, co-director of the ECG Processing Center; and Dr. Robert Q. Marston, president of the University.

this complex surgery. Especially needed is teamwork in the operating room where special precautions must be taken to assure that vital brain functions such as speech and memory are not impaired as a consequence of removing the epileptic focus.

At a more basic level, a team of neurologists, neurosurgeons and neuroscientists have developed the first reliable animal model of post-traumatic epilepsy. They found that a single injection of iron salts into the brain cortex of rats resulted in chronic localized seizures, originating in the area close to the injection site. With the newfound ability to duplicate the epileptiform activity in rats, the investigators are seeking new pharmacologic agents to prevent development of epilepsy following head injury.

Sparing the Knife

In pediatrics, recent clinical investigation of various endoscopic instruments, such as the thoracoscope, has provided numerous children with a safe, effective alternative to major surgery for diagnostic purposes. More than 100 children with suspected pulmonary problems have had their lungs inspected via thoracoscopy as an alternative to open lung biopsy. The investigators report the technique has helped them achieve 100 percent accuracy in diagnosing pneumocystic pneumonia, about 95 percent accuracy in detecting inflammatory diseases of the lungs, and about 89 percent accuracy in spotting tumors of the lungs.

Using the thoracoscope, it is possible to obtain a panoramic view inside the chest without major surgery, thereby reducing risk to the patient's life. Since light anesthesia is used during the procedure, the patient can respond to the physician's instructions to breathe deeply, to cough, or to report discomfort. No complications have been associated with thoracoscopy.

UF neurosurgeons also have expanded usage of recently refined endoscopic instruments to see inside the brain while accurately placing shunt systems in children with hydrocephalus. The procedure involves using a special needle to form a narrow passageway through the brain for insertion of the endoscope. Then, with an illuminated view inside the brain, the surgeon positions the shunt tube in the lateral ventricle. Peering through the endoscope, the surgeon can see exactly where the end of the shunt tube is being placed . . . avoiding the necessity for cumbersome X-ray pictures to confirm shunt location.

Saving Sight

During the 1960's and 1970's, the UF Eye Clinic became one of the world's leading centers for investigating various applications of soft contact lenses, both in the correction of visual abnormalities and as protective bandages in the treatment of such diseases as corneal ulcers and blisters, and various dry eye syndromes. Bandage soft lenses have served as a simple, inexpensive method for curing or controlling hundreds of cases of blinding corneal diseases such as keratitis.

UF ophthalmologist also have conducted extensive clinical investigation of new permanent-wear soft lenses for optical correction of aphakia and found them satisfactory to most patients. The same permanent-wear soft lens is being used, with encouraging results, in the treatment of keratoconus.

Other ophthalmology researchers are making new inroads in early surgery and early visual corrective measures for children with congenital cataracts. Among the first to perform cataract surgery on infants during the first few weeks of life, UF ophthalmologists believe it is important to initiate corrective measures while the child's visual system still is in critical stages of development. The protocol for visual correction includes the use of a new



Fig. 3. — Recently developed microsurgical techniques have made it possible for neurosurgeons (like Dr. Albert Rhoton Jr. above) to enter some critical areas of the brain and spinal cord and accurately remove life-threatening tumors or tangled blood vessels. More than 400 practicing surgeons from throughout the world have come to the UF's Microneurosurgery Training Laboratory to learn the latest techniques.



Fig. 4. — University of Florida student Robert Harper is among the first eight Florida youths with diabetes to receive insulin treatment via a battery-powered infusion pump. Pediatric endocrinologists report that based on preliminary patient responses, it appears that the pump helps keep insulin levels in balance on a continuous basis. The device may prove useful in preventing the common problems of overtreatment or undertreatment with insulin . . . especially in patients with brittle diabetes mellitus.



Fig. 5. — Mrs. Ann Snyder (above) of St. Louis Mo. was totally blind for twenty years, until she received a new corneal prosthesis last November. The device was implanted by Dr. Frank Polack, above right, at the University of Florida Shands Teaching Hospital. Mrs. Snyder returned home a few weeks later with the newfound ability to read large print, to distinguish faces and objects, to enjoy full color vision, to see her own home and grandchildren. Although she has very limited peripheral vision, she has greatly increased her mobility.

type of soft contact lens, corrective glasses and eye patches, all aimed at restoring binocular vision.

An interdisciplinary research team also is gaining new insights into the beginning stages of diabetic retinopathy, long before the patient is aware of any visual distortion. Using sophisticated testing procedures such as layer-by-layer perimetry (being developed at UF), the researchers can locate the exact layer or layers of the retina which may be affected by abnormalities, and detect changes caused by tiny aneurysms. In gaining a clearer description of how retinopathies develop, they also hope to develop a method for earlier, more effective treatment of the disease.

In a separate UF study, new information has been reported on the mechanism by which the retinal receptors maintain alignment and facilitate sight—specifically how these special light sensitive cells change alignment in response to manipulation of the light entering the eye. Detailed studies of visual function in healthy volunteers (with normal eyesight), suggest it may be possible to develop effective techniques for correcting misalignment of retinal receptors.

Strides in Diabetes Treatment

Last year, pediatric endocrinologists at UF joined endocrinologists at Yale University in the early testing of a new insulin infusion pump for patients with brittle, insulin-dependent diabetes mellitus. Evaluation of the pump in treatment of eight Florida youths during the past year is so far resulting in better management of the

disease than was achieved previously through standard once-a-day insulin injection. The battery-powered device, usually worn on the belt, injects insulin subcutaneously round the clock on a preset schedule, with large doses emitted before meals and snacks.

Researchers say the greater accuracy achieved by the pump in meeting the patient's continuous need for insulin is helping prevent overtreatment or undertreatment with insulin. Although the system is effective in keeping insulin levels in balance, the present model is too bulky and "in the way" for some of the younger patients to tolerate on a continuing basis. Miniaturized insulin pumps, now being developed, may help solve this problem.

Straightening Bones

A UF orthopedic surgeon, who developed a new surgical technique via animal research during residency training at the Medical College of Virginia, brought his expertise to the UF and has shared it with colleagues across the state and nation. This procedure has been performed on more than 125 children who were developing angular bone deformities or unequal length of limbs as a consequence of injury to the growth plates.

In more than 80 percent of the patients, the procedure has proven successful in straightening the bones, restoring growth, and reducing discrepancy in length of limbs. Removal of bony scar, often bridged over the growth plate, is removed prior to setting the bone in proper alignment. The corrective procedure involves an insert of silicone elastomer, which is molded against the cut surfaces of the bone and the growth plates. The silicone implant hardens and stays in place, preventing the reformation of bone scar, so that normal bone growth can continue.

Research Becomes Service

A basic research project, which developed into a widely accepted diagnostic service for cardiologists, is



Fig. 6. — Using the surgical microscope to provide high magnification, obstetrical surgeons at the University of Florida Shands Teaching Hospital perform the delicate procedure of reconnecting fallopian tubes which previously were tied or clamped to prevent conception. Although several Florida women have given birth to healthy babies after undergoing such surgery at Shands, the physicians caution that success is possible only in a select few women who have sufficient length of fallopian tubes remaining in good condition, and who are otherwise healthy.



Fig. 7. — More accurate assessment of a child's heart function, based on the electrocardiogram and vectorcardiogram, may be in the future. Dr. B. Lynn Miller, far right, assistant professor of pediatric cardiology, has been collecting extensive ECG data on hundreds of children from infancy through the teenage years . . . both healthy children and others with known cardiac disorders. Miller's work is part of a nationwide study.

the Regional Computerized Electrocardiogram Processing Center. Emanating from recently expanded headquarters on the Health Center's ground floor, the ECG analysis system now benefits 25 Florida hospitals. More than 60,000 electrocardiograms are transmitted over telephone lines from the participating rural and urban hospitals every year.

The system has been found to attain a 90 percent accuracy rate in diagnosing contour abnormalities and simple rhythm abnormalities. A recent innovation in the system is the development of a computer program for comparing several ECG's from one patient and "reporting" any changes detected over time. The result of such comparative analysis is a progressive picture of a patient's heart function over a span of several days (such as during critical intensive care), or over several months or years.

The comparative ECG analysis system is being evaluated at the Shands Teaching Hospital prior to implementation on a regional basis. In related research, a UF pediatric faculty member is completing one segment of a nationwide study aimed at compiling data on the progressive changes which take place in children's heartbeats as they grow from infancy to the teen years. Electrocardiograms and vectorcardiograms have been secured on 1,500 healthy children and 500 children with known cardiac abnormalities—data which will be combined with similar information obtained by cardiology researchers at six other university medical centers. Based on the accumulated data from some 11,000 children across the nation, computers can be programmed to analyze a child's ECG on the basis of criteria which is relevant to that child's age, sex and race. NIH funds the study.

In 1978 alone, approximately $14,000,000 in research grants were awarded to the UF College of Medicine. With such support, UF medical scientists continue their commitment to further improving diagnosis and treatment of disease, as well as to expanding knowledge of normal bodily functions. These ongoing research efforts are expected to continue making significant impacts upon both the quality of patient care and the education of future health practitioners.

Great souls have wills, feeble ones have only wishes.

Chinese proberb

Profile:

Dr. Hugh Hill, Student's Friend

Dr. Hugh M. Hill, "Smiley," has been Associate Dean for Student Affairs at the University of Florida for 15 years. He is a living institution and is deeply respected and loved by *all* those who have had the opportunity to know him—faculty and students alike. The only person to win the coveted Hippocratic Award twice, Dr. Hill shares some of his feelings about students of medicine.

Many University of Florida graduated physicians now in practice across the State and nation will remember a familiar quip of Dr. Hugh Hill, "You can run, but you cannot hide."

Sometimes, students found out how much he meant it when he picked the fellow in the far end seat on the back row to ask the first challenging question. As Associate Dean for Student Affairs for 15 years, he has given more meaning to the phrase by tracking the progress of every individual from entry into medical school and later into professional practice. While the lack of a hiding place could prove worrisome, few if any of the graduates have complained of being shadowed by the man with dancing eyes and ready laugh who willingly goes to bat for students in tough situations.

Year by year, "Smiley" Hill has watched the Health Center grow, kept abreast of rapid changes in medical practice, and experienced major changes in the curriculum. Yet all the while, he says "there have been few significant changes in the students themselves. Fads of clothing and hairstyles have changed, but the student today likely will run into some of the same academic 'snags' that frustrated students in the 1960's and 1970's.

"The only real difference I can recall was during the late 1960's when there was so much student unrest throughout the country," says Hill. "Many of our students during that time were aggressive in asking what really was relevent to their education and what was not relevant, as if they knew," he said with a chuckle. "In recent years, there has been some swing-back in terms of student attitudes."

Hill uses another pet phrase, "The lessons of history are plain that problems repeat themselves," as he describes past encounters with students struggling through tough courses and challenging clinical rotations. An example, which has astonished many students, is his uncanny ability to pinpoint the source of low performance on a test. Confronted with a student upset after the grades came in, Hill often has asked, "Did you study alone?" The typical student response is "How did you.



Fig. 1. —Dr. Hugh Hill, Professor of obstetrics and gynecology and Associate Dean of Student Affairs for 15 consecutive years, reveals the happy personality that won him the nickname "Smiley."

know?" Then, like a knowing teacher in a fatherly stance, Hill explains that "invariably, those who run into academic difficulty are tackling the mountain single-handedly." With so much material to master, he explains that it helps to be with others and find out what they think is most important."

As a teacher, advisor and chief problem-solver for students, Hill said he has found that motivation is the most important, but least predictable factor in determining who is likely to succeed academically and later in medical practice. "If you exclude extenuating circumstances such as illness, marital turmoil, divorce and similar severe personal problems, the lack of motivation is the leading cause of failure," he says.

In contrast to the problems arising from diminished motivation, Hill says he has observed remarkable instances of highly motivated students who did not have the best academic credentials upon admission, but finished as honor graduates. "I've been somewhat amused, in the past, to discover that about 30 percent of those graduates selected for membership in Alpha Omega Alpha (medical honor society) were those who did not have the best grade point averages and other high credentials initially," he said.

As an active practitioner in his specialty of obstetrics and gynecology and as a teacher, Hill has won the acclaim of students year after year as one of their favorite and most inspiring mentors. In 1969, he was selected by students as first recipient of the now traditional "Hippocratic Award for Teaching Excellence." Seven years later, despite the fact that the award was not supposed to be given to the same faculty member twice,



Fig. 2. —Dr. Hugh Hill shares a laugh with medical students in the graduating class of 1975, shortly after they presented him with the Hippocratic Award for Teaching Excellence. Overshadowing the scene is a now historic "Tree of Hippocrates," grown from a sapling taken from the Mediterranean plane tree under which Hippocrates presumably taught young physicians during the fifth century B.C. on the island of Kos, Greece. The tree is still thriving.

students chose him again as "the teacher who best exemplifies the ideals of Hippocrates in patient care and in teaching." During other years, graduating classes of physicians have fabricated other teaching honors for him, such as "The Royal Order of The Trumpet Award" from the class of 1977.

Sometimes it is the funny events that most endear Smiley Hill to the students. Dr. Orvin Jenkins, now a general surgeon in Gainesville, remembers the day when Hill was placing slides in a very old projector, and asking students to identify the disease which was represented in the tissue sample. The old projector became overheated, melting the parafin on the edges of the slide, and the tissue began to move. A student had just said he could not identify the disease, when Hill said, "Well you can see it metastasizing before your eyes; does that give you any hint?"

Another day, Jenkins recalls when a group of students were in the labor and delivery area with Dr. Hill and a student said he could not believe what he had heard . . . that Hill was a fitness buff who could do one-handed push-ups. At that, Dr. Hill hit the floor and performed ten push-ups (one hand to the floor).

Another former student, Dr. Dan Fisher (class of 1978) wrote a tribute to Dr. Hill in song, presenting the composition during annual class skits. UF graduate Dr. John Nelson (now practicing psychiatry in Gainesville) recently commented, "Whenever I think of teachers who made the greatest impressions on me, I remember those who were truly enthusiastic about teaching. That's what I liked about Hugh Hill . . . his great enthusiasm."

Hill doesn't think there is any magic involved. "If anything is effective in teaching students, it must involve spending time with them, not forgetting your own past struggles as a student," he says. "You must treat them as you'd like to be treated, and of course treat them with honesty." He adds a bit of philosophy, "The nature of the curriculum actually plays third to the more important aspects of student motivation and faculty members who can (and do) inspire the students to become more than they otherwise would have dreamed of becoming."

Of the curriculum, he says, "The lessons of history are plain that every ten years, things will be shaken up and something 'new and innovative' will be proposed. In reality, very little is new."

With whatever curriculum is in vogue, Hill says "the bottom line is do you turn out a product who can do well?" Hill says, "It has been pleasing to us to see how well our graduates are doing in practice and to hear how pleased they've been with the experience they got here. Our dropout rate has been extremely, and happily, low. One key factor is that at the outset, we let the students know that we, the faculty, want them to succeed. We've had some gratifying results in 'restoring' students who were floundering. I remember one who had to repeat two years, but today is doing a marvelous job in practice.

"With students who are marginal, we usually can feel comfortable about graduating them if we can positively answer three important questions," says Hill. Those questions are: Are they willing to work? Are they honest? Do they recognize their own limitations?

Only once during the college's history, Hill recalls "we made the alarming discovery that an imposter had been enrolled. Perhaps we were not as smart as we should have been, but neither were we expecting anything like this," he said. The student, who had attempted to live up to someone else's name and someone else's academic credentials, was dismissed.

Regarding the clinical preparation of physicians, Hill says that "having a tertiary care facility like Shands as a primary location for clinical training has been an asset. It is clear that in this kind of state referral hospital, you receive the rare, complicated problems and a relative dearth of the more routine illnesses. But by the time medical students leave here, they have been well indoctrinated, as evidenced by the good feedback we get on their performances during internship and residency training elsewhere."

Equally gratifying to the popular Dean of Students has been the way many UF graduates keep in contact with the faculty long after they've joined the working ranks. In addition to sending Christmas cards and paying return visits during UF Homecoming and special events, former students sometimes call Dr. Hill for consultation on a puzzling patient problem. It is then that Hill reinforces the professional friendship-partnership that began when the calling physician was an anxious freshman medical student. And often, the consultation ends with a friendly word of encouragement or the familiar rippling laugh which somehow diminishes the tensions and stress of a busy day.

Trust your hopes, not your fears.

Spotlight on Hazel Donegan



The name Hazel Donegan is a household word on the lips of every College of Medicine graduate. Miss Donegan has had more prolonged and direct influence on the happiness of each individual student than any other person.

Hazel Donegan was in on the ground floor of establishing the University of Florida's College of Medicine.

Several years before the school opened, she was working with Dr. T. Z. Cason, a practicing physician in Jacksonville. He had supported the need for medical postgraduate education in Florida, and imbued Miss Donegan with the need to support such efforts, too.

In 1940, the Florida Legislature repealed the laws which prevented the establishment of a medical school, and in 1956, the school finally opened.

At that time, Dr. Cason encouraged Miss Donegan to take a job in Gainesville to work in postgraduate education.

"I came to Gainesville for two years . . . and stayed for 20," she said.

Four years later, she transferred to the undergraduate student activities office, which she now directs. This office handles all applications, financial aid and state licensure procedures and maintains records for 466 students.

What does it take to smooth the administrative path for so many students?

Miss Donegan offers modesty and a true commitment to the students with whom she works.

"We just want them to know we are available to them, and we care about their lives, in and out of the Health Center," states Miss Donegan.

"When they first come to medical school, many students are strangers, to each other and to the system. We do what we can to make them feel welcome," she explains.

This can range from help with a financial aid form, to reminders of deadlines, or to just being a good listener.

"You can't help but get involved with students and take their problems home along with yours," she relates, "They're such a nice group of people."

The feeling is mutual. The graduating class of 1968 dedicated its yearbook, *Retrospectroscope*, to her.

In 1974, they did it again.

"To the person we feel has contributed the most to helping us through our four years. Always cheerful and never too busy to see a student. It is with gratitude and respect . . ." is the quote accompanying that dedication.

Miss Donegan is a memorable person in the life of each of the former graduates of the College of Medicine. She has been the recipient of numerous gifts including trips to Europe by two graduating classes.

Within Hazel Donegan lies the symbolism of the true mission of all future physicians—"caring."

Recently "Hazel" made statements concerning her retirement—hopefully that decision will be handled in the same way in which she arrived—"I came to Gainesville for two years and stayed for . . .".

Profile:
Four Academic Pioneers Who Stayed To Help the Health Center Grow

Dr. Thomas Maren, Dr. Arthur Otis, Dr. Edward Woodward, and Dr. Richard Smith are four of the original chairmen who started with the University of Florida College of Medicine and remain to share their memories of what it was like at the College of Medicine's beginning.

Imagine a gaping hole in the ground, in the middle of a cow pasture, bordering the two-laned country road from Gainesville to Archer.

Think of no shopping malls, few apartments, a one-hospital town with one not so fancy restaurant named Ruby's just outside the limits of a dry county, and no jet service, but a nice slow train that whistled straight into the heart of town.

Such was the scene when pioneer academicians like Drs. George Harrell, Russell Poor, Thomas H. Maren and Arthur Otis came in the mid 1950's to finish building and staffing the University of Florida Health Center.

Tom Maren, who left a research position with the American Cyanamid Company in Stamford, Conn. and moved to Gainesville in December 1955, remembers well the days of planning and building a faculty from temporary offices in a white frame building downhill from today's Health Center.

"I was there with Frank Putnam (biochemist), James Wilson (anatomist), and Josh Edwards (pathologist), and up the hill about 100 yards were Dr. Poor and Dr. Harrell. Often when Harrell and Poor would get into planning sessions, they would say 'let's go down the hill and see what the boys think.' Then one day in March 1956, we marched up the hill and told them we were the executive committee," recalls Maren.

"I remember how the five of us, including Dr. Otis, who left Johns Hopkins to join our faculty in the summer of 1956, wore many hats. We were not only the executive committee; we were the search committee for new faculty, the curriculum planning committee, and the organizers of major departments in the medical college. And to think, some people on the main campus wondered what we were doing while we didn't have any students!"

"In the founding days, it sometimes was difficult to attract ambitious young physicians who were afraid of launching their careers at an unknown school," said Maren. "What we ended up with, largely, were the venturesome types who were excited by the challenge. There was a great sense of pulling together and of pride, both in the departments we were organizing and in the college we were building."

Today, Dr. Maren, who chaired the Department of Pharmacology for 22 years and remains active as a Graduate Research Professor, and Dr. Otis, chairman of the Department of Physiology since the college opened in 1956, look back with wonderment at immense changes. Both have stayed with the Health Center, building strong



Dr. Thomas Maren is now Graduate Research Professor in the Department of Pharmacology and Therapeutics of which he was chairman for 23 years.

programs of education and research. Not the least of changes they've seen is the swelling of enrollment in the basic medical science courses, from 36 students in 1956 to nearly 200 medical and dental students today.

Maren remembers there were 20 faculty members in 1956; you could count their cars on the parking lot and know who was here. Otis also recalls when he and several colleagues made newspaper headlines because they bicycled to work!

Two other charter faculty members, also department founders, researchers and active clinicians . . . Dr. Richard Smith and Dr. Edward Woodward . . . have been in on the action throughout the institution's 24-year growth. Smith, who founded the Department of Pediatrics and directed it through the first challenging decade, recalls the curiosity with which many local residents eyed the new medical staff as the teaching hospital was making its community debut in 1958. "must have looked awfully young then," said Smith. One Gainesville woman who came into the hospital looked at me and said, 'You're supposed to be taking care of babies out here and you're one yourself.' In truth, we were so new as a clinical faculty that we had no patient contacts and for awhile, we accepted everyone who came through the door, as long as they came by proper physician referral."

"We opened on the fourth floor, and all kinds of people came to see us," said Smith. "There were few of us on the staff and we took turns on call. I even helped Woodward in the operating room. I remember the first case we scrubbed for . . . a child with severe bowel obstruction caused by worms. I made the initial diagnosis, asked a skeptical Ed Woodward to consider the surgery and then helped him in the OR."

"What happened soon after the hospital opening was dramatic," Smith recalls. "We received the patients with rare and complicated problems which were puzzling to Florida physicians . . . so much so that almost every patient was a research project. This was the first time I had worked in a rural area where people often waited too long to seek a physician's help. Among our first patients, for example, was a child brought to the hospital comatose. In fact, he almost died before we determined that he was suffering with a curable, genetically based Vitamin B-12 deficiency; only two such cases had been reported in medical literature. I was fortunate to find reports of the other two cases in time and to administer effective treatment," he said.

"Soon we discovered that our original mission was somewhat unrealistic for the time and place we found ourselves in," said Smith. "The institutional mission, as initially conceived, was to raise a generation of primary care physicians who would study and train with nurses and other health professionals and then set up team practices in rural areas of need. Yet medicine itself was changing rapidly during this time and what Florida really needed was a tertiary care center where seriously ill patients could be sent for highly specialized care."



Dr. Richard Smith became the first Chairman of the Department of Pediatrics in 1958. He resigned in 1967 to become the Chairman of the Pathology Department and the C.V. Whitney Marine Research Laboratory at Marineland.



Fig. 3. — On Oct. 20, 1958, a little girl named Nancy Sue Smith of Williston became the first patient at the University of Florida Teaching Hospital. Greeting her was Dr. Richard Smith, founding chairman of the Department of Pediatrics (now chairman of the Department of Pathology). During the first month of its first fiscal year of operation (June 1959), the hospital rendered 1,564 days of care to 212 patients. By 1965, the hospital was caring for some 300 inpatients every day.



Fig. 4. — Ten years after the opening of the teaching Hospital, Nancy Smith returned to Gainesville to participate in the celebration and to greet another young patient.

Smith recalls one case in point was the pressing need for an open heart surgery team. "We saw many children in need of heart operations, but we had to refer them outside the state until we could gear up a cardiac catheterization laboratory and a team of specialists in heart disease," he said. By May of 1959, Dr. Woodward had employed Dr. Myron Wheat (now in St. Petersburg) as UF's first cardiovascular surgeon, and an eight-year-old child from Tampa became the first open heart surgery patient at the teaching hospital.

Ten years later, major efforts were focused on development of a surgical team skilled in kidney transplantation. The state's first "live" kidney transplant was performed in 1969. That first patient, then a UF law student, is feeling well today and is active in professional practice.

Smith, now chairman of the Department of Pathology and director of the C.V. Whitney Marine Research Laboratory at Marineland, said Shands Teaching Hospital owes its successful beginning to more than its own hard working staff and state resources. "One thing that really stands out in my mind was the incredible, all-out support we received from private practitioners. They took a chance, sending us many referrals," said Smith.

"I remember especially colleagues like George Palmer and Raney Oven in Tallahassee; Tom Brill in Gainesville; Hugh Carithers and Dick Skinner in Jacksonville; Andy Townes, Orlando; Henry Morton, Sarasota; Gordon Heath and John Moore, Lakeland; R. Bell and John Whitcomb, Pensacola; George Hopkins, St. Augustine; Ted Dippy, Winter Park; and Bernard Ohara, West Palm Beach.

Man for the Hour

What attracted medical scientists like Maren, Otis, Smith and Woodward to a fledgling medical school can be summarized in two phrases which each of them expresses differently: the fun of new beginnings and a man named George Harrell.

Woodward describes Harrell as "the most attractive academic director I've ever seen, an extremely idealistic leader who was at the same time very imaginative and sometimes delightfully informal. Every Sunday morning, I would see him at the Health Center in a sports shirt, cleaning up his office and taking care of dictation he didn't have time for during the week."

Otis recalls how clearly Harrell stated the Health Center's philosophy and objectives to the faculty and to the public and how concerned he was with the minute details of the Health Center's architecture, right down to the last brick and tile.

Maren says Harrell was clever in understanding the needs of individual faculty members and wise in setting forth multiple missions for the Health Center, giving high priority to research as well as to the education of physicians and other health professionals.

"One accomplishment of Harrell which became an attracting factor for myself and other founding faculty members was his early development of the medical library," said Maren. "He employed Fred Bryant to spend a year in Europe buying old medical journals and books, and garnered support from the Commonwealth Fund to



Dr. Edward Woodward remains chairman of the Department of Surgery which now comprises 7 divisions.

meet special needs such as the establishment of our departmental libraries," he said.

Woodward recalls working with Harrell and with Dr. Peter F. Regan III (now practicing in Buffalo, N.Y.) in drafting the initial medical practice plan which continues to serve as the modus operandi for all patients in medicine, pediatrics and surgery. That unwritten plan, says Woodward, specified that every patient would be utilized fully for the teaching of physicians and that each would receive the same high quality of medical care. We also developed the concept of group practice, with a unified business management system that would free the teaching physician from "the grinding nonsense of paper work."



Dr. Arthur Otis, founding Chairman of the Department of Physiology, resigned September 1979, but remains as Acting Chairman until a new chairman is chosen.

As a practicing surgeon and as chairman of the surgery department for 23 years, Woodward has found himself constantly at the brink of new developments. He recalls when Myron Wheat and Roger Palmer (a member of the first UF graduating class, now chairman of pharmacology at the University of Miami) developed the use of pharmacotherapy in the treatment of patients with dissecting aneurysm. "This signal development has drastically reduced the death rate in these patients," says Woodward.

Another major UF development, says Woodward, was that of myocutaneous flaps, a technique involving the simultaneous transplantation of skin with its underlying muscle tissue. "This major advance in reconstructive surgery was developed here by Dr. Leonard T. Furlow, Jr., now in private practice in Gainesville; Dr. Maurice J. Jurkiewicz, now practicing in Atlanta; and Dr. John McCraw, now in Norfolk, Va.," he said.

Woodward has brought to the University, and to Florida, skilled pioneers in many subspecialties of surgery. In the process, he has been a partner in the development of refined techniques in many specific aspects of pediatric, cardiovascular and orthopedic surgery; the implementation of new microneuro-surgical techniques for delicate excision of tumors inside the brain and spinal cord, as well as for bypassing obstructed cerebral arteries; and improved microsurgical skills employed in the replantation of severed fingers and toes, and in the successful reversal of tubal ligation.

Woodward has seen a continuing trend in subspecialization of surgeons. "Within orthopedic surgery alone (now a separate department chaired by Dr. William Enneking), we have surgical specialists in sports medicine, oncology, children's orthopedics, fractures and hand surgery. We also have surgeons specializing in pediatric urology and urologic oncology, and of course, many of the upper gastrointestinal problems such as post gastrectomy complications come to me," he said.

"As the capabilities of practicing surgeons throughout Florida have expanded and improved greatly over the years, the patients referred to our surgical services have become more complex," said Woodward. "The total improvement, in the care of Florida patients, has been dramatic. It has been our job to keep abreast of the current patient problems and the latest medical-surgical techniques for correcting them . . . a task that has kept me on the road 60 days out of every year," he says. "Keeping up calls for active involvement on the national scene, as well as direct personal involvement in research," he adds.

Woodward, like other UF medical leaders who continue to plow new ground in their academic disciplines, seldom thinks in the past. For one thing, the surgical calendar is filled far into the future and there is a new challenge. Plans are being finalized for a separate trauma surgery team, being organized in cooperation with hospitals throughout North Central Florida. The mission will be very prompt triage of every trauma patient, and the implementation of a strict protocol in the care of every patient, including widespread use of radio interplay between ambulance personnel and the surgical trauma team.

"We're doing a pretty good job now, but we want to do it better," says Woodward. "The quicker you get an injured patient to the hospital and administer the proper treatment, the better the chances of helping that person live; it's that simple." (When the trauma team is fully mobilized, Shands Teaching Hospital will qualify as a Class I institution according to trauma care guidelines established by the American College of Surgeons.)

Thus, pioneers often remain pioneers, ever running ahead. Perhaps the mood is best expressed in a quote from one of Woodward's favorite authors Satchel Page: "Never look behind you; someone may be gaining on you."

Health Center Milestones

September 1956	*Medical Sciences Building opens; Colleges of Medicine and Nursing accept their first students*
October 20, 1958	*University of Florida Teaching Hospital admits its first patient, nine-year-old Nancy Sue Smith of Williston*
May 4, 1959	*First open-heart surgery is performed on eight-year-old Cheryl Ann Duncan of Tampa*
September 1959	*College of Health Related Services accepts its first students (entering their junior year)*
November 11, 1959	*Ground is broken for $2 million pharmacy wing, providing for relocation of the College of Pharmacy from the main campus*
November 21, 1959	*Teaching Hospital and Clinics are formally dedicated*
June 1960	*College of Nursing graduates its first class of 26 baccalaureate nurses*
June 6, 1960	*College of Medicine graduates its first class of 40 M.D.'s*
February 26, 1961	*University of Florida Hospital Auxiliary is organized under the leadership of the Medical Guild. Mrs. Mary Ballard is elected first president*
June 5, 1961	*College of Health Related Services graduates its first class of 14 baccalaureate health professionals*
March 1, 1962	*Department of Ophthalmology opens new eye clinic and teaching service*
March 1962	*Hospital receives an artificial kidney machine, one of four dialysis machines in the state at the time*
March 1962	*Birth Defects Treatment Center for Children is established with a grant from the National Foundation-March of Dimes*
April 17, 1962	*College of Pharmacy (relocated from main campus) dedicates new $2 million complex*
October 1962	*Clinical Research Center opens its doors to patients. The 10-bed "hospital within a hospital" is funded by a $2 million grant from the U.S. Public Health Service*
October 1964	*College of Health Related Services is renamed College of Health Related Professions*
September 8, 1965	*Ground is broken for Phase I of the Human Development Center*
November 27, 1965	*Hospital is officially named the W. A. Shands Teaching Hospital and Clinics in honor of former State Senator William A. Shands of Gainesville*
September 1966	*Maternal and Infant Care Program is initiated in the Northcentral Florida region with a grant of over half a million dollars from the Department of Health, Education and Welfare. The program is a cooperative venture between the state's Division of Health and the UF College of Medicine*
February 16, 1967	*The first fully-endowed chair in the University's history—the J. Wayne Reitz Chair of Reproductive Biology and Medicine in the Department of Obstetrics and Gynecology—is made possible by a gift of $750,000 from Mrs. Cordelia Scaife May of Ligonier, Pa.*

March 31, 1967	*Paul Peek, 17, of Satellite Beach becomes the 100,000th patient to be referred to the Shands Teaching Hospital and Clinics*
April 15, 1967	*Phase I of the Human Development Center—the Jessie Ball DuPont Building housing the Children's Mental Health Unit and the Developmental Research Unit—is dedicated*
September 25, 1967	*Gainesville Veterans Administration Hospital opens across Archer Road from the Health Center (dedicated October 22)*
November 1967	*College of Medicine and the Jacksonville Hospitals Educational Program, Inc. announce a partnership to strengthen programs of graduate and continuing medical education in Jacksonville, thereby creating essentially the first medical education extension division of UF*
January 6, 1969	*The Lafayette County Health Center treats its first 17 patients, representing the first attempt by the Colleges of Medicine and Nursing to provide comprehensive ambulatory health care to an unselected population group outside the Hospital (dedicated March 1)*



PARTNER IN EDUCATION, PATIENT CARE, RESEARCH

The Veterans Administration Medical Center, connected by underground tunnel to the University of Florida Health Center, has been much more than a neighbor since its construction in 1967. Today, more than 85 staff members at the VAMC have appointments on the faculties of the Health Center colleges (primarily medicine), and some 35 Health Center faculty members receive VA support for research. Several hundred UF medical students, residents, and fellows in various graduate training programs use the VA Medical Center for part of their clinical experiences. The VA facilities continue to grow. A 120-bed nursing home, south of the existing complex, is expected to be completed by April 1980. Another $20 million worth of expansion, now in design phases, will provide new space for ancillary support, education and research.



June 1969	*College of Medicine Class of 1969 initiates the annual Hippocratic Award for Teaching Excellence. Dr. Hugh M. Hill is the first recipient*
October 28, 1969	*First kidney transplant from a live donor is performed on Jimmy Acosta, a UF law student*
September 1970	*First total hip replacement operation is performed*
April 2, 1971	*Rev. Thaxton Springfield Orthopaedic Study and Research Center is dedicated. The Center is a unique regional museum for the study of pathological process in virtually every known orthopaedic disease*
May 22, 1971	*Ground is broken for a $38 million expansion project including the Dental Sciences Building, Communicore Building and three patient floors for the Shands Teaching Hospital*
June 1972	*Becky Lee Tyler, 10, from Oak Hill, Florida is the Hospital's 200,000th patient*
September 1972	*College of Dentistry accepts its first class of 24 students*
September 1972	*Physician's Assistants Program is established as a joint project of Santa Fe Community College and the UF College of Medicine*
February 27, 1973	*Establishment of the Dr. W. C. Thomas, Sr. Chair of Obstetrics and Gynecology is announced*



The cow pasture which became the site of the sprawling University of Florida Health Center was an arcadian scene in the early 1950's. It was distinguished by the University's ornamental horticulture greenhouses, lower left; an orange grove, a railroad siding which cut into the campus and permitted service to the heating plant; and parts of the old Flavet Village (upper right hand corner).

A crowd of dreamers and planners gathered under cloudy skies on June 1, 1954 to break the sod in preparation for the University College of Medicine and eventually, a complex of six colleges and two hospitals. Mrs. J. Hillis Miller of Gainesville was among the participants.



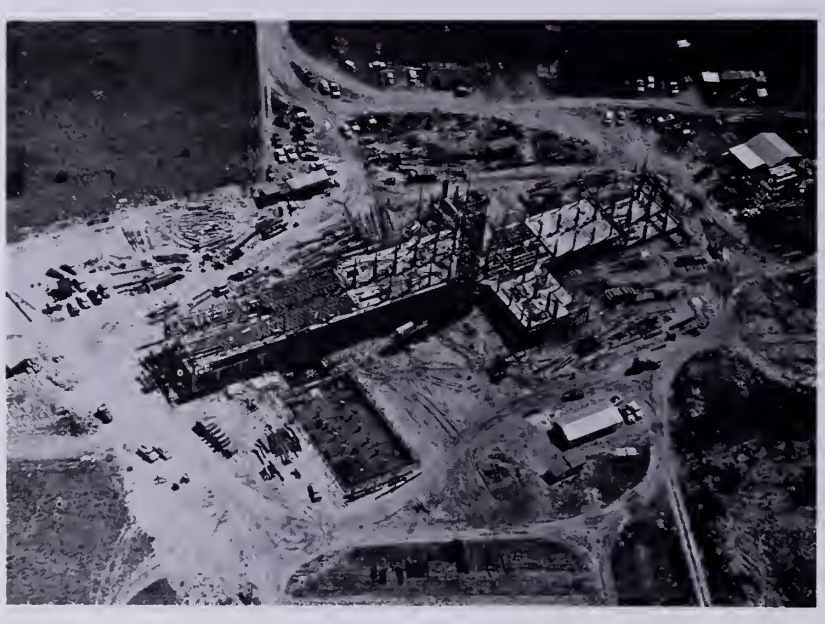


Dr. George T. Harrell Jr., founding Dean of the College of Medicine, drove the dragline at the first groundbreaking ceremony. With him on the historic occasion were Sen. J. Emory (Red) Cross; the late Sen. William A. Shands for whom the teaching hospital was later named; Rep. Ralph Turlington (now State Commissioner of Education); and Dr. John Allen, then Acting President of the University of Florida.



The first footings, on the floating foundation of the proposed University of Florida Health Center, provide an interesting record of early beginnings.

From the air, the first outline of the Medical Sciences Building rises from the pastureland. The forward extension from the far left end of the building became the first home of the Health Center Library. The frog pond at lower right was later filled and today is part of the parking lot.



As the structure took place, planners of the Health Center were busy in temporary wooden shacks down the hill...recruiting faculty members, drafting the first curriculum, screening applicants for the charter class of medical students, drafting operational plans and policies for the Teaching Hospital and Clinics, scouting for library books, and seeking more financial support.



By May 16, 1957, the completed Medical Sciences Building was being connected by long corridors to the building that would house the teaching hospital and clinics. The first two classes of medical students were busy at work in classrooms and laboratories at the left end.



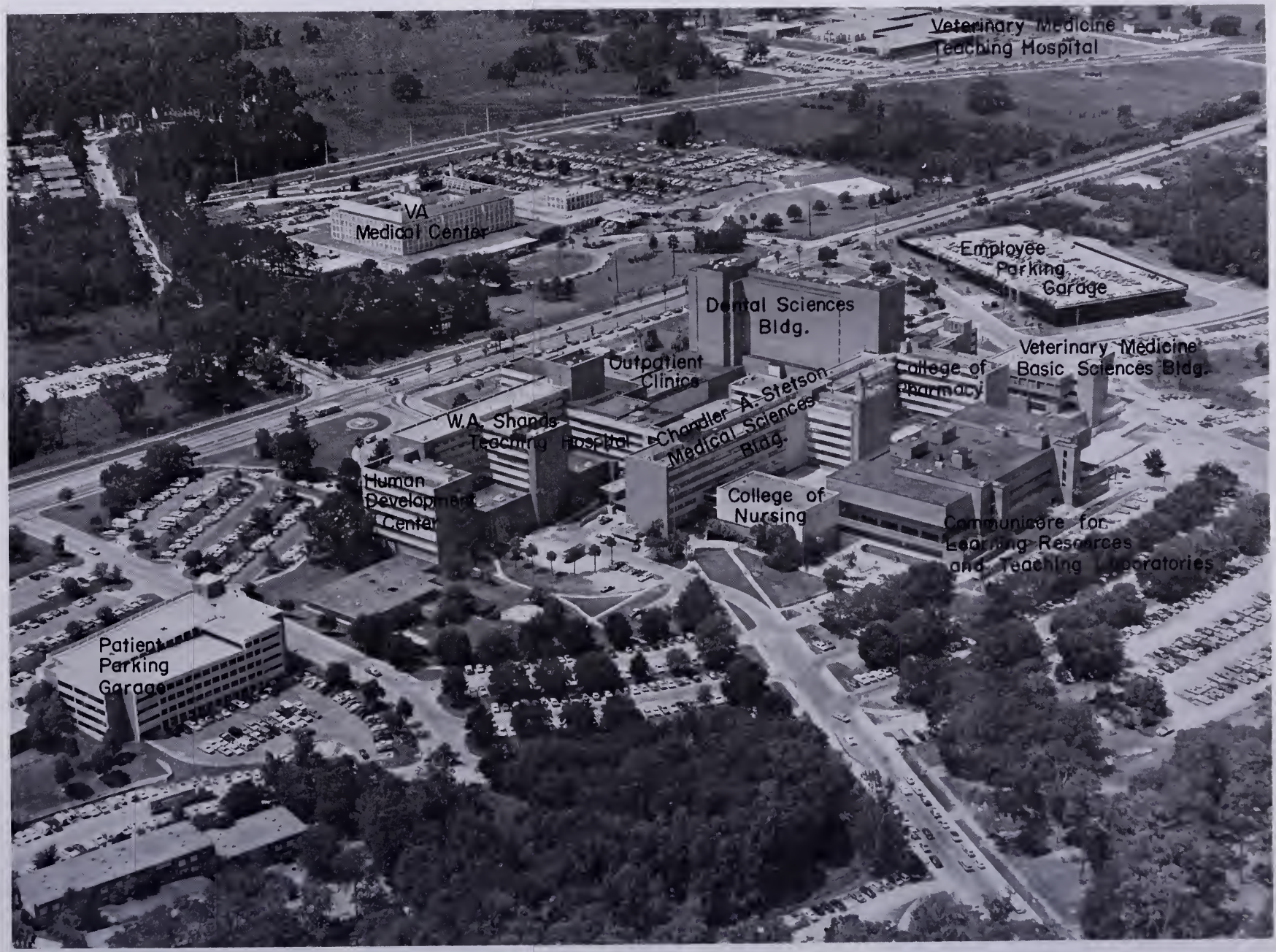
In April of 1968, the Florida Board of Regents approved a $30 million building expansion program destined to double the size of the 12-year-old Health Center. Major components of that expansion included the 11-story Dental Sciences Building (upper view with elevator shafts completed first) and the Communicore Building, below.

Dr. George T. Harrell, founding Dean of the College of Medicine; Dr. Perry Foote, founding Dean of the College of Pharmacy (now retired and living in Gainesville); and Jefferson Hamilton, who was then consulting architect to the University of Florida.





Many shovels turned up the earth during groundbreaking ceremonies for the University of Florida Teaching Hospital and Clinics. Participating in the event were, left to right: Mike Wood, first director of the hospital (now director of the University Medical Center in Jacksonville); Rep. Ralph Turlington (now State Commissioner of Education); Sen. J. Emory (Red) Cross; Dr. Samuel Martin, first chairman of the College of Medicine's Department of Medicine; Dorothy Smith, founding Dean of the College of Nursing; the late Sen. William (Bill) Shands; Dr. John S. Allen, Vice President of the University of Florida; and Dr. J. Wayne Reitz, President of the University.



THE J. HILLIS MILLER HEALTH CENTER — 1980

Health Center Milestones

July 1, 1973	*The Family Practice Residency Program is begun as a cooperative venture of Alachua General Hospital and UF College of Medicine's Department of Community Health and Family Medicine to prepare family physicians for practice primarily in rural areas*
July 6, 1973	*Establishment of the Dr. Harry Prystowsky Chair of Obstetrics and Gynecology is announced*
January 2, 1974	*First 20-year rechargeable pacemaker is implanted in six-year-old William Tyner of Ocala*
October 3, 1974	*Communicore Building opens, providing new library, teaching labs, lecture halls, animal research facility and Learning Resources Center*
October 16, 1974	*James Richmond Boulware, Jr. Pediatric Library is dedicated*
January 6, 1975	*The Theodore Gildred Microsurgery Education Center opens as the first of its kind in the U.S. to train surgeons in the latest microsurgical techniques*
May 17, 1975	*Ground is broken for the Veterinary Medical Teaching Hospital to be constructed adjacent to the VA Hospital*
August 1975	*Occupancy of the new Dental Sciences Building, providing space for the College of Dentistry as well as expansion of several major outpatient clinics and support services of the Shands Teaching Hospital*
September 1975	*Bid is awarded for the College of Veterinary Medicine's new Basic Sciences Building, to be constructed on the southwest corner of the Health Center complex*
May 1976	*Ground breaking for Veterinary Medicine Teaching and Research Building*
June 11, 1976	*College of Dentistry graduates first class*
July 1976	*"The Picture of Health"-a weekly half hour TV show designed to inform the public about medical research and health education is started by Health Center Communications*



THE COMMUNICORE:
SERVICE TO ALL COLLEGES

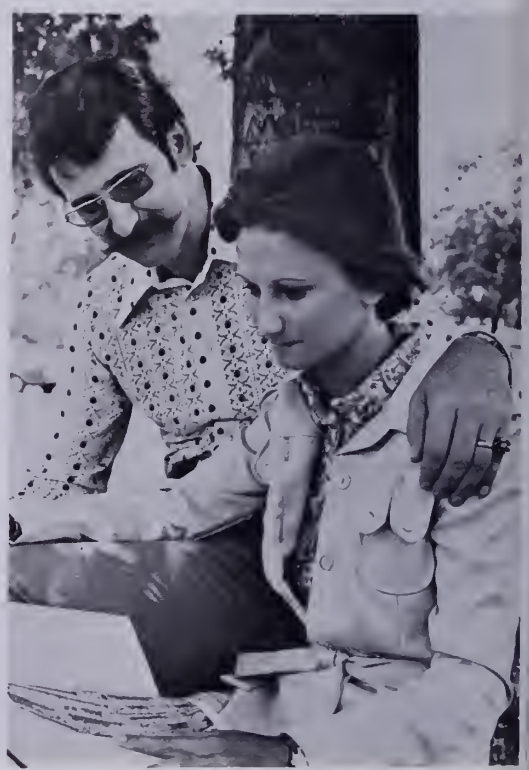
One of the newer parts of the Health Center complex...the Communicore Building...is the home of a large modern Health Science Library, a ground-floor Animal Resources facility, multi-purpose teaching laboratories and lecture halls. On the third floor is Learning Resources and Communications which serves the institution via the production of audio visual teaching programs, medical photography and graphic illustrations, and a communications staff which shares newsworthy events of the Health Center with the public through newspaper stories, radio broadcasts statewide, and a weekly television program (The Picture of Health) on nine television stations.



MAJOR ADDITION: COLLEGE OF DENTISTRY

This eleven-story Dental Sciences Building, occupied in the Fall of 1975, became the home of the State's first dental college, and a long-awaited addition to the Health Center complex. The first three levels of the dental building also provided room to expand several overcrowded clinics, including the emergency room of the Shands Teaching Hospital. Today, the dental college is the training site for 235 predoctoral students and 10 postdoctoral students, aided by a faculty of 84. Patient clinics established by the college, both within the Health Center and at a modern satellite clinic in the rural town of Mayo, now provide dental care for thousands of Florida residents.

September 1976	*Jeannie Nelson, daughter of John Nelson, M.D., College of Medicine class of 1964, became the first child of a College of Medicine graduate to enter Medical School at the University of Florida*
September 1976	*First class entered the College of Veterinary Medicine*
September 1976	*Eugene L. Jewett, M.D., endows Department of Orthopaedic Surgery chair after 40 years of Orthopaedic Surgery practice in Florida*

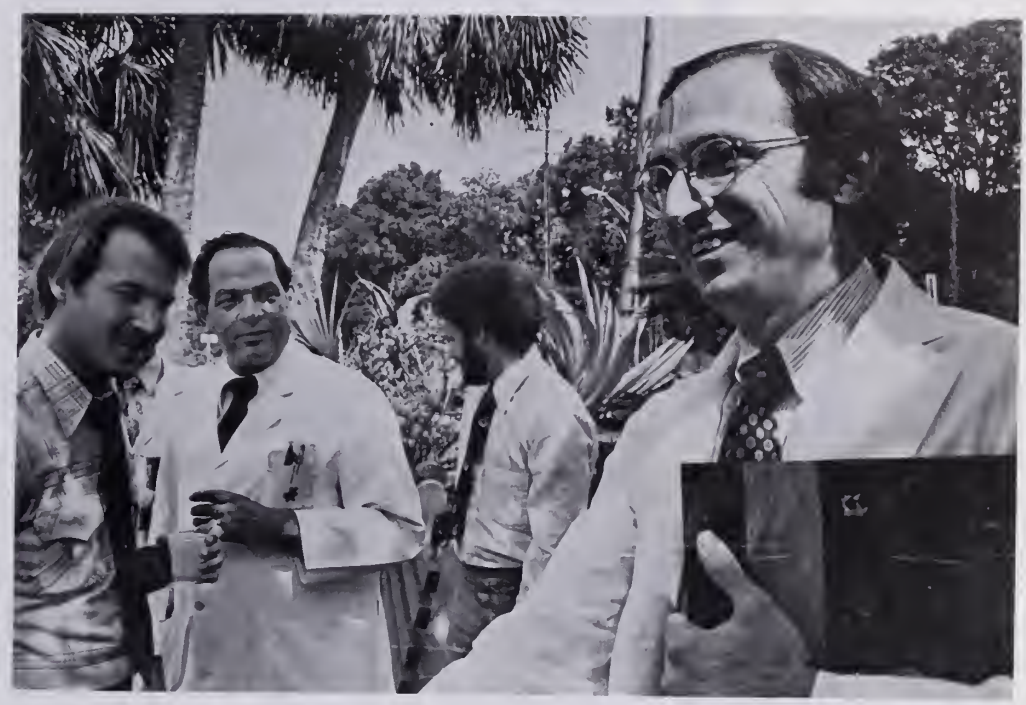


FOLLOWING DAD'S MEDICAL TRACKS

Sixteen years after Dr. John F. Nelson graduated from the University of Florida College of Medicine, he has the pleasure of seeing his daughter Jeannie graduate this year from the same college. While "Dad" pursues a busy psychiatry practice in Gainesville, Jeannie plans to enter residency training in neurology (the site not yet determined). She was the first child of a UF medical alumnus to enter the same college.

UF GRADUATE BECOMES POPULAR TEACHER

Dr. James Patrick O'Leary, a 1967 graduate of the University of Florida, was the students' choice as most outstanding clinician-teacher in 1977. Dr. O'Leary became the first UF alumnus to win the annual Hippocratic Award for Teaching Excellence. Today, he is chief of the Department of Surgery at the VA Hospital in Nashville. After completing his housestaff training at Shands, he served as an associate professor of surgery with the UF College of Medicine from 1972 to 1978.





NEW NAME FOR AN OLD BUILDING

The former Medical Sciences Building, oldest unit of the Health Center complex, was renamed in memory of the late Dr. Chandler A. Stetson during ceremonies two years ago. Dr. Stetson served as Dean of the medical college from November of 1972 until his death in May 1977...the last three years of which he also served as Vice President for Health Affairs. Stetson Hall today is a lasting tribute to a man who left an outstanding record of service as a medical scientist, teacher and administrator.

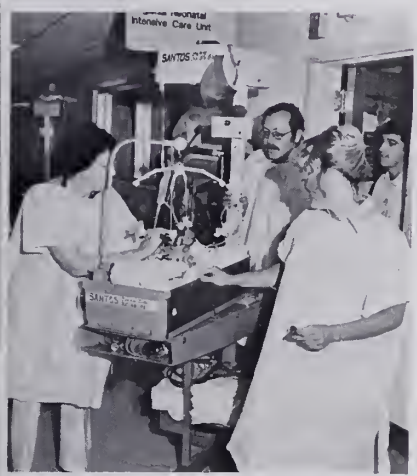


BETTER CARE FOR BURNS

A $238,000 six-bed burn unit, located on the fifth floor of Shands Teaching Hospital, was dedicated in September 1978. During the ribbon-cutting ceremonies, tribute was paid to the late Dr. Eugene Tubbs, (M.D.), a former Shands resident who was instrumental in obtaining funds for the burn unit while serving in the State Legislature. The expanded facility includes a small operating room for skin-grafting procedures and an area for hydrotherapy.

October 1976	*Doctor of Pharmacy degree program inaugurated (Pharm. D.)*
February 1, 1977	*Mr. John Ives named New Shands Teaching Hospital director from University of Connecticut Health Center*
March 18, 1977	*William F. Enneking, M.D., Chairman, Department of Orthopaedic Surgery, appointed to the Eugene Jewett Chair of Orthopaedic Surgery*
May 1977	*The College of Medicine class of 1977 awarded The Hippocratic Award to James Patrick O'Leary, M.D., College of Medicine class of 1967. Dr. O'Leary is the only University of Florida College of Medicine graduate to receive this award*

May 25, 1977	*Chandler A. Stetson, Jr., M.D., Vice President for Health Affairs and Dean, College of Medicine, dies*
September 1977	*Dr. Thomas Maren, first Chairman, Department of Pharmacology and Therapeutics, receives honorary M.D. degree from Uppsala, Sweden*
September 1977	*New Family Practice Center opens*
January 1978	*Michael Schwartz, Ph.D. is named new College of Pharmacy Dean*
February 10, 1978	*Medical Sciences Building dedicated The Chandler A. Stetson Medical Sciences Hall, and the Chandler A. Stetson Professorship of Experimental Medicine is established*
April 25, 1978	*William B. Deal, M.D. is named Vice President for Health Affairs and Dean, College of Medicine - Dr. Deal has been Associate Dean since 1973*
April 21, 1978	*Linear accelerator and new radiation therapy facility dedicated*







TENDER CARE PAYS OFF

When a new, expanded Regional Neonatal Intensive Care Unit opened at Shands Teaching Hospital in 1978, the first entering patient was a Tampa, Florida infant named Jacqueline Joanne Santos. The highly specialized medical and surgical treatment she received, to correct a defect of the esophagus, paid off happily. Tiny Miss Santos went home for Christmas (1978) with her parents, Mr. and Mrs. John Santos, and was able to eat normally for the first time.



ANOTHER STATEWIDE RESOURCE

Latest addition to the Health Center, although located a few blocks away from the main campus off Archer Road, is the Veterinary Medical Teaching Hospital. In addition to serving as the primary site for clinical teaching of Doctors of Veterinary Medicine, the hospital is a statewide resource for the care of animals with rare and complicated diseases. Faculty members in the College of Veterinary Medicine, like those in Medicine, also are engaged in research and in community service projects.

September 30, 1978	*The F. Eugene Tubbs, M.D., Intensive Care Burn Unit and The Regional Neonatal Intensive Care Center open*
December 4, 1978	*Dr. Blanche I. Urey, Dean, College of Nursing, dies*
December 1978	*The "R.D. Keene Family Professor of Neurosurgery" chair established by a $1 million endowment, Dr. Albert L. Rhoton, Chief of the Division of Neurosurgery, was named to the chair*
February 1979	*Expanded Regional Computerized Electrocardiogram Processing Center dedicated*
February 1979	*Faculty chair in Geriatrics established by Dr. Ruth Schwartz Jewett of Winter Park*
March 31, 1979	*College of Veterinary Medicine dedicated consisting of patient care, educational and research facilities*
July 1, 1979	*Shands Teaching Hospital becomes non-profit corporation*
July 1979	*Legislative approval for a $40 million loan to Shands Teaching Hospital for construction of a patient services building-anticipated groundbreaking March, 1980*
November 3, 1979	*The Jerome Johns Hyperbaric Facility dedicated*
December 1979	*Dr. Lois Malasanos from the University of Illinois is named new Dean of College of Nursing*

ADVANCE IN HYPERBARIC MEDICINE

A new multi-person hyperbaric chamber which may be used as a self-contained intensive care unit was dedicated at the University of Florida's Shands Teaching Hospital in November 1979. During the public ceremonies, Dr. William Deal (left) Vice President for Health Affairs, expressed thanks to Rep. Frank Williams and to Mr. and Mrs. Jerome Johns for their help in obtaining the facility. The chamber was named in honor of Johns, a businessman in Starke, Florida, and the son of former Florida Governor Charlie Johns. Johns was treated successfully for gangrene in the old one-person hyperbaric chamber at Shands following a tractor accident in 1977, and subsequently campaigned for state funds to construct the new chamber facility. The chamber itself is on loan to Shands from the National Aeronautics and Space Administration (NASA). It is one of four such chambers in Florida able to treat patients with a pressure equivalent to that found at a depth of 165 feet under water.



SPECIAL ARTICLE

Commencement Address

Paul G. Rogers

Distinguished faculty, families and friends of the graduates but most importantly the graduating class of 1979 — congratulations!

I am honored, first of all, to be present at your graduation, to be able to say to each of you for all present today: "Congratulations. You've done it!" To express to you the pride felt by your supporting and helpful families — mothers, fathers, husbands, wives and friends — pride in your accomplishment graduating today from medical school to become doctors. And, I'm sure also, to express the satisfaction of this distinguished faculty in helping and seeing you reach this significant step in your individual lives.

Secondly, I am honored to be present at your graduation because having attended the University of Florida undergraduate and law schools I feel a special bond to the University and its graduates. Also, the President has been my long-time friend. His leadership and innovative ideas have made him a recognized international leader in higher education and particularly in the health and science fields.

Thirdly, I am honored to be at your graduation at a time in our national life when problems of significant magnitude present daily challenges to the best in all of us. Columnist Art Buchwald in his graduation speeches tells the graduates, "We're handing you a perfect world — Now don't go out and mess it up."

But challenges we have:

Energy — and the shortage is here!

Inflation — and prices are rising.

Standby controls — and the Congress has not acted.

The Middle East — Salt II — and the desire for peace.

Health care — your own special concern — and the decisions that must be made regarding: Health costs — #1 concern of American people, maldistribution of health personnel, exploding health technology — proper use, national health insurance — choice among President Carter's incremental plan, Senator Kennedy's more encompassing plan, or even Senator Ribicoff and Senator Long's catastrophic illness health plan.

Although we have the finest health care in the world, there are still gaps in the system. What action should be taken to close the gaps?

Any of these national concerns could be the basis for a graduation speech — of challenges for the future! But none of these subjects is what I want to talk about today. I want to talk to you — graduate — about you and the great excitement and experience of your life ahead, as you walk out these doors today, with an opportunity to carry out a plan of action already determined to reach your goal and for others what may still be only dreams but for all of you the opportunity to continue to grow in knowledge and to live your life to the brim.

Too often we see people trained in a particular profession (law, medicine, dentistry, health sciences, architecture, pharmacy, etc.) living in a cacoon, blocking out other interests, consumed only by developments in that profession, restricting friendships and contacts (idea exchange) to other members of that profession.

I want to talk about your individual interests and talents that you possess and have nurtured from school-days and experiences to today's college graduation and what you will do with those interests and talents in the future. And what better time or place to think about you — individually you — as you end this phase of your life and start your participation in the full of American life.

Perhaps the most outstanding example in America of a person who developed in full his talents and interests — a renaissance man — was Thomas Jefferson. Think about Thomas Jefferson a moment — a humanist and universal man whose firm belief in "self-evident and

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Mr. Rogers is a former Florida Congressman from West Palm Beach. This address was delivered before the graduating class of the University of Florida College of Medicine, May 1979.

inalienable rights" has brought dignity and emphasis to every individual human being in this nation.

Jefferson, a father of our democracy and an apostle of political, religious and intellectual freedom — a universal man with interests and knowledge in fields of science in numerous branches, architecture, agriculture, inventions, religion, philosophy and languages. Professor Karl Lehman in his book on Jefferson tells us that the pursuit of knowledge by Jefferson was unending and never stopped even in the 17 years after his graduation, if you please, (retirement) from the Presidency of the United States. This pursuit of knowledge in terms of mind and spirit was the richest of all his years!

The real essence of Jefferson's living and humanism was that he recognized no barriers to the operation of the mind and sought constantly to make knowledge useful, not just to accumulate knowledge but to use it.

Jefferson felt strongly when he said, "The earth belongs always to the living generation."

How do you make knowledge useful? Apply it in your daily living, in your relations with your family and your friends, in your profession! Expand your own knowledge in as many areas as is realistic and stimulating, expand your talents.

Keep your life full and exciting with knowledge. Continue to build your own knowledge blocks on the cornerstones you have constructed to date in this University and put them to use in daily living.

Make up your mind now, like Jefferson, that mediocrity has no place in your life — in your living! No mediocrity in your work as you deal with human lives but rather a fuller effort. No doing just to get by. That's no fun or challenge.

In all your living and actions — no mediocrity. Do things with zest and vigor, enthusiasm — no half-way living. As your life touches others, in dealing with your fellow human beings, family and friends, no mediocrity of affection. Let 'em know if they're friends, tell them so. And tell them what they mean to you. And when you love someone, show it, and tell them "I love you!" No mediocrity of affection.

I know this 1979 Graduating Class is ready to face the future with knowledge and confidence, ready to be doers, ready to live fully.

What a day!

What a time!

What a graduation class!

Truly, the earth belongs to the living generation. God speed.

The person who advances is not the one who is afraid to do too much; it is the one whose conscience will not permit him to do too little, the one whose driving desire is to give the best that is in him, even though it may seem at times like casting bread upon unreturning waters.

B. C. Forbes

ORGANIZATION

Dr. Daniel B. Nunn of Jacksonville Is JFMA Editor-Designate



Daniel Brunson Nunn, M.D., a Jacksonville thoracic and cardiovascular surgeon, will become the next Editor of *The Journal of the Florida Medical Association.*

The appointment of the 49-year-old South Carolina native was announced by FMA President-Elect T. Byron Thames, M.D., of Orlando, and approved by the Board of Governors at its meeting in January.

In May, Dr. Nunn will succeed the present Editor, Gerold L. Schiebler, M.D., of Gainesville, who was ineligible for reappointment under a Board of Governors policy limiting terms of JFMA editors to five years.

"I am deeply grateful to President-Elect Thames and the FMA Board for giving me this important opportunity to serve the FMA," Dr. Nunn commented. "Dr. Schiebler has been a great editor who has left a lasting imprint upon the history of *The Journal*, and we shall endeavor to continue this tradition of excellence."

No stranger to medical journalism, Dr. Nunn is a former Editor of *Jacksonville Medicine*, and was Guest Editor for JFMA's Special Issue on Thoracic and Cardiovascular Surgery, which was published in October 1979. He also has served on *The Journal*'s consulting editorial staff since 1974, representing first the Florida Society of Thoracic and Cardiovascular Surgeons, then the Florida Chapter, American College of Surgeons.

Dr. Nunn, the ninth physician appointed Editor of JFMA since the founding of the publication in 1914, is a native of Columbia, S.C. He graduated from the University of South Carolina in 1951 with a B.S. degree in chemistry and a Phi Beta Kappa key.

He received his M.D. degree in 1955 from the Medical University of South Carolina, where he was a member of Alpha Omega Alpha. He took a rotating internship and residency training in general and thoracic

surgery at the Teaching Hospitals of the Medical University of South Carolina, 1955-1961.

During his years at the Medical University of South Carolina, Dr. Nunn served as a Fellow in Vascular Surgery and a Teaching Fellow in Surgery. He was certified by the American Board of Surgery in 1962 and by the American Board of Thoracic Surgery less than a year later.

Dr. Nunn is Chief of Thoracic and Cardiovascular Surgery at Methodist Hospital in Jacksonville, where he was Chief of Staff in 1976-1977. He also is on the Active Staff of University Hospital of Jacksonville, St. Luke's Hospital and St. Vincent's Medical Center. He is a Clinical Assistant Professor of Surgery of the University of Florida College of Medicine/Jacksonville Hospitals Educational Program.

The new Editor-Designate is the author of 16 editorials published in *Jacksonville Medicine* and *The Journal* and is the author or co-author of 45 scientific papers in his specialty.

In addition to the Duval County Medical Society, the FMA and the American Medical Association, Dr. Nunn's professional memberships include: Southern Surgical Association; Southern Association for Vascular Surgery (charter membership); International Cardiovascular Society; Southeastern Surgical Congress; Society of Thoracic Surgeons; Southern Thoracic Surgical Association; and the Florida Society of Thoracic and Cardiovascular Surgeons, of which he was President in 1976-77.

Dr. Nunn is married to the former Gloria Lee Smith, the current Treasurer of the FMA Auxiliary.

They have three children: Myra, 21; Daniel, 18; and Andy, 14.

The June 1980 number will be the first issue of JFMA published under Dr. Nunn's direction.

JFMA's Editorial Heritage

When he takes office in May, Daniel B. Nunn, M.D., will become the 9th Editor of *The Journal of the Florida Medical Association*.

***The Journal* first appeared on July 18, 1914, under the editorship of Graham Edward Henson, M.D., of Jacksonville, one of two men to serve twice in the post. The other was Shaler Richardson, M.D., also of Jacksonville, whose combined total of 33 years of service is by far the record for longevity among JFMA editors.**

Two Editors — Clyde M. Collins, M.D., of Jacksonville, and Gerold L. Schiebler, M.D., of Gainesville — were the first limited to terms of five years under a policy adopted by the Board of Governors in the 1970s.

Following is a list of all JFMA Editors and their terms of service.

Graham Edward Henson, M.D. Jacksonville	**1914-1918**
E. W. Warren, M.D. Palatka	**1918-1919**
Graham Edward Henson, M.D. Jacksonville	**1919-1925**
Shaler Richardson, M.D. Jacksonville	**1925-1944**
Homer L. Pearson, M.D. Miami	**1944-1947**
Shaler Richardson, M.D. Jacksonville	**1947-1961**
Thad M. Moseley, M.D. Jacksonville	**1961-1968**
Franz H. Stewart, M.D. Miami	**1968-1970**
Clyde M. Collins, M.D. Jacksonville	**1970-1975**
Gerold L. Schiebler, M.D. Gainesville	**1975-1980**
Daniel B. Nunn, M.D. Jacksonville	**1980-**

Leadership Conference at Lake Buena Vista Draws Record Attendance

A record number of 241 officers and others from county medical societies, representing 96% of FMA's membership, took part in the January 26 - 27 Leadership Conference at the Dutch Inn, Lake Buena Vista. The meeting was for the purpose of providing an up-to-date report on FMA's current and proposed activities and programs.

FMA President Richard S. Hodes, M.D., of Tampa, told those in attendance that the task of getting issues and attitudes out to the membership, along with receiving feedback, is the most difficult job he has faced as President. "The annual meeting is not the proper setting for just sitting down and swapping ideas, whereas this meeting is designed as a place where county society officers and executives can receive information about what is going on in FMA," he said.

He was followed by FMA Secretary Robert E. Windom, M.D., of Sarasota, who spoke on FMA's 1979 - 80 priorities. Dr. Windom described the priorities as well-outlined and well-executed. "You are the conduit through which information must move to all the membership," he told the group.

Dr. Windom called for improved communications with specialty societies. "We cannot afford to fragment into individual groups," he said. "We have to have the clout of a strong FMA when dealing with the Legislature and others on behalf of organized medicine."

Cost of Medical Care

The cost of medical care was one of the main themes throughout the conference. Dr. Windom pointed out that through the efforts of the AMA and the FMA we have so far been successful in both justifying and holding down the cost. He emphasized that it is a constant battle that must be kept before the public. "There is nothing wrong with profit when we can show it goes to benefit the patients through improved care," he said.

More utilization of a strong Auxiliary is also a priority. "They have the time and capability," Dr. Windom said. In the area of public relations, he called for furnishing more factual information to the public through radio and television programs. "Go down and talk to your stations about local issues and ask for public service time," Dr. Windom urged.

He also decried the current status of emergency medical service in Florida. "Changes have caused us to slip from third to forty-third in quality of EMS. We are deeply concerned about that and hope to achieve some type of straight-line authority within government to correct the situation. At the same time we must expand our efforts in PMUR if we don't want the bureaucrats telling us what is wrong," he said.

In other areas, Dr. Windom termed the Florida Health Data Corporaton as healthy and doing well; FMA as one of the outstanding associations in the country with a "quality and dedicated staff"; the creeping tide of HMO's as something that must be watched daily; and the transmittal of information to colleagues as a priority.



FMA President Richard S. Hodes, M.D., presides at opening session of Leadership Conference. Others in picture: President-Elect T. Byron Thames, M.D., and Secretary Robert E. Windom, M.D.

FMA Finance and Management

Dr. Hodes rendered a joint report on the scope of activities of FMA councils and committees, and finance and management. He pointed out that it has become increasingly imperative that we continually scrutinize our priorities in order to allocate the Association's finances to preserve the basic principles of organization and protect the best interests of the membership to the best of our ability.

Part of this effort has been a careful evaluation of the composition and functions of the Association's councils and committees. Every effort has been made to streamline and consolidate wherever possible. A special meeting with council and committee chairmen was held during the October Board meeting. At that time they were requested to review carefully the current activities of their individual councils and committees and to submit their comments ranking the importance of their activities, with recommendations regarding those that could be eliminated. They have also been asked to evaluate these activities as to their direct benefit to the membership or the public.

The Board of Governors has made an in-depth review of the past history and current financial status of the Association. FMA has consistently maintained sound management and there has been a staff reduction from 50 to 42 employees. The Association sold the FMA headquarters building in January for a profit of $600,000 based on a $300,000 cash investment two years ago. FMA had approximately a $500,000 net profit from the closing of the Harlan-Med insurance operation and the organization of PIMCO as a replacement. Dr. Hodes observed that this clearly indicates the aggressiveness of the Association in seeking sources of income other than dues.

"I can assure you," Dr. Hodes reported, "that your Association is in sound financial condition today. However, with the inflationary factor of our economy, a decision must be made in the not-too-distant future whether to further reduce association activities and staff or seek other sources of income such as a dues increase.

"A special committee that I appointed with approval of the Board of Governors is now conducting an in-depth review of this Association's finances and will report back to the Board of Governors at its March 15th meeting." The committee is composed of Jere Annis, M.D., of Lakeland, former Vice Chairman of the Board of Trustees of AMA; T. Byron Thames, M.D., of Orlando, President-Elect of FMA; and J. Russell Forlaw, M.D., of Boynton Beach, FMA Treasurer.

Florida Physicians' Insurance Reciprocal

Vernon B. Astler, M.D., of Boynton Beach, Chairman of the Board of the Reciprocal, reported that at the end of 1979, the Reciprocal insured 6,400 physicians out of a potential market in Florida of approximately 10,000. The Reciprocal offers three levels of coverage: $500,000; $1,000,000; and $1,500,000.



President-Elect T. Byron Thames, M.D., (left) and Past President Louis C. Murray, M.D., engage in some lunchtime conversation.



Congressman Bill Nelson addresses the luncheon session.

He observed that the FMA-sponsored medical malpractice tort reforms enacted by the Legislature during the period 1975 - 78 have helped to improve the loss experience in Florida. Since their inception, the success rate before mediation panels has been approximately 91 to 92%. Under constant attack by plaintiff attorneys, the constitutionality of mediation panels is again being reviewed by the State Supreme Court. Loss of the panels could result in higher premiums for 1981.

For 1980, premiums were reduced by 1.5% for third and fourth year physicians. There were further reductions of the first and second year members over prior years. After its first year of operation, the Reciprocal declared a dividend equivalent to 7.35% of the 1978 premium which amounted to approximately $1.77 million. During 1979 the Reciprocal declared a dividend to the policyholders of $1.0 million.

As anticipated, claims activity developed slowly, due to the claims-made coverage, but began to accelerate during 1977 and 1978 and continued into 1979. *During 1979 claims frequency and severity escalated to a level which is causing concern and may be reflected in 1981 premiums.*

To date, claims paid and costs of the claims investigation and defense has amounted to $8.033 million while another $32.898 million has been set aside in reserve for reported claims and expenses of investigations and claims defense.

Life Insurance Company

The Reciprocal received a permit on December 31 from the Florida Insurance Department to organize a life insurance company. This new company was capitalized with $1.5 million and is a wholly owned subsidiary of the Reciprocal. It is being formed for the following reasons:

1. For tax advantages to the Reciprocal through filing joint returns after five years of coexistence.
2. For investment purposes. A profitable life insurance company could sustain the Reciprocal during difficult years.
3. For the promotion of quality products at low cost to the policyholders.

The Reciprocal has also invested approximately $3 million in income-producing real estate.

Public Relations Activities

Speaking later in the program as the Association's public relations officer, Dr. Astler said for years physicians have "labored in dignified silence" and paid the price for it. "Unfortunately, in our dignified silence we were letting others distort our image," he said.



Past President Jack A. MaCris, M.D., reports on various government investigatons of FMA.



Henry M. Yonge, M.D., Chairman of the FMA Committee on Continuing Medical Education, discusses the FMA CME program for conference participants.

Dr. Astler pointed out FMA must address three publics: the FMA membership, the media and the lay public. He stressed good relations with the media as of utmost importance. He and other officers feel the visits with major newspaper editorial boards around the state were extremely beneficial for both sides.

Afternoon Session/Legislative Workshop

"Recovery of Costs in Civil Proceedings" will be the big issue on which FMA will mobilize its full resources during the 1980 Legislature, David C. Lane, M.D., of Fort Lauderdale, Chairman of the Committee on State Legislation, told a packed audience attending the afternoon session on Legislative activities. The Association does see several other critical issues with which it will have to deal, including: support for efforts to control the cost of medical care consistent with the FMA's position; defeat of efforts to weaken or dismantle Florida's county health units and of any legislation to further regulate the private health care community, such as certificates of need for physicians' office equipment; and passage of legislation relating to confidentiality of medical records.

Four areas of concern at the national level were identified by Louis C. Murray, M.D., of Orlando, Chairman of the Committee on National Legislation. They are National Health Insurance, Hospital Cost Containment, HMO Reimbursement and the Federal Trade Commission.

Dr. Murray also reminded the group that the FMA has allocated funds to bring Florida Congressmen home for the specific purpose of addressing county medical societies on issues of interest. To take part in this program society representatives should contact the FMA Capital office.

Sunday Morning Session

The public is satisfied with the quality of medical care, but not the costs, according to John F. Lee, M.D., of St. Petersburg, Chairman of the Florida Committee on the Cost of Medical Care. "New technology costs and patients want it. If we do our jobs well, we are going to increase costs by prolonging life," he said. Inflation, hospital labor and compliance with governmental regulations were identified as major cost factors.

Auxiliary Involvement

The FMA Auxiliary's involvement in the Association's legislative program has been substantially expanded this year. "We have made the first step to bring them in as full partners. The Auxiliary offers a new element and we are urging that representatives be placed on all county society legislative committees," Francis C. Coleman, M.D., of Tampa, Chairman of the Legislative Council, said.



Mr. David Pingree, Secretary of the Florida Department of Health and Rehabilitative Services, discussed the programs and problems of his Department on Sunday morning.

Former Senate President Mallory Horne and current President-Designate W. D. Childers told the conference that physicians should not stay out of the process just because they do not know all about a bill. Their message was that your legislators want to hear from you. They emphasized that if physicians are truly concerned over legislative matters, they will involve themselves, their wives, and their families in the legislative process.

William G. Myers, M.D., of Hobe Sound, a member of the Florida House of Representatives, speaking from a physician's legislative point of view said his interest is in preserving the private practice of medicine. "No longer does an isolated group lobby against a bill. They all get together. You still aren't involved enough," he said.

Luncheon Address by Rep. Nelson

Florida's physicians and hospitals were urged to hold the line on patient costs or the government will do it for them by U.S. Representative William Nelson (D-Melbourne. "If you don't start doing it, you are going to

get one of those punitive types of legislation which are coming along," Rep. Nelson told the luncheon session.

He told the group that they knew and he knew costs had not been held down in the past. He said that a survey of his district in 1978 showed 49% of the people favored a national health insurance program. "If a conservative district like this is responding, then you can imagine the pressure the more liberal districts are bringing on their legislators," he said.

Department of HRS

David Pingree, Secretary of the Department of Health and Rehabilitative Services, said it is time for his agency and FMA to join hands and lock arms together on those issues on which we agree. "We need coalition and cooperation, rather than confrontation," he said. Pingree sees many issues where both organizations are in agreement.

On the other hand, the Secretary does not see the need for a separate Department of Health, an FMA goal for several years. As to county health departments, Pingree's position is they should continue as a local and state partnership between the County Commissions and Department of HRS. "We are not attempting to take them over," he said.

Government Investigations

FMA remains under siege from the Federal Government, according to Jack A. MaCris, M.D., of St. Petersburg, Chairman of the Committee on Health Regulatory Activities. As of one year ago there were seven investigations of the Association underway. Two have been resolved and five are continuing.

"As all of this activity raises its head around us, we must not lose sight of our role in formulating responsible policies that neither restrain trade nor abdicate the medical profession's traditional concern for quality care. We can survive the continuing attacks by government, but we cannot survive a loss of public support in our professions," Dr. MaCris commented.

Status of Litigation

FMA has been successful thus far in its suit against HEW seeking to block release of the list of physicians and fees they received from Medicare, according to Legal Counsel John Thrasher. He also pointed out the Association may have to enter litigation to prevent release of similar Medicaid information by the State Department of HRS. A ruling was also expected soon on a petition filed with the State Department of Commerce seeking a 35% increase in the medical and surgical fee schedules for Workers Compensation Board.

Mr. Thrasher also reported the constitutionality of mediation panels has again been raised before the Supreme Court of Florida as to the operation of the statute. A ruling on that issue is expected soon. The FMA Legal Counsel is also monitoring the status of counter-suits and said at this time he was aware of three favorable settlements in that area.

The FMA is also considering litigation to prevent the placing of signs in physicians' offices advertising a toll-free number to call with "complaints".

Continuing Medical Education

A concise summary of FMA's CME program was presented by Henry M. Yonge, M.D., of Pensacola, Chairman of the Committee on Continuing Medical Education. He announced recent action by the Board of Governors in modifying the Appeals and Suspension Procedures. One such modification was to allow that physicians who were delinquent in the FMA continuing medical education requirements as of December 31, 1978 will now have until October 31 of this year to complete the program. The future delinquent date will be on April 1 with automatic suspension on October 31 for noncompliance.

He also said that FMA will soon convert to a centralized and computerized continuing medical education reporting system, relieving county medical societies of the record-keeping burden.

County Medical Societies

Officers of Dade, Brevard and the Panhandle County Medical Societies discussed their programs and problems for the edification of the group. The recurring theme, from large to small, was communications and interaction. Participating were Manuel L. Carbonell, M.D., President of Dade; Brian P. Gibbons, M.D., President of Brevard; and K. Sinclair Franz, M.D., Secretary of Panhandle.

Scientific Publications

On Friday, prior to the beginning of the conference, approximately 40 physicians and staff members attended the annual joint meeting of the FMA Committee on Scientific Publications and the panel of consulting editors of *The Journal.*

Prof. Charles G. Wellborn of the University of Florida College of Journalism and Communications presented an interesting critique of *The Journal* and county medical society bulletins. All eleven county medical society bulletins were represented by their editors or staff.

Three Additional Annual Meeting Programs Are Announced

Three more scientific sections have been announced for the 106th Annual Meeting of the Florida Medical Association.

According to Calvin W. Martin, M.D., of Arcadia, General Program Chairman, the Florida Pediatric Society and the Florida Association of Nuclear Physicians will combine to present a joint program on Friday afternoon, May 9.

Other programs were announced by the Florida Society of Colon and Rectal Surgeons for Friday afternoon and by the Florida Obstetric and Gynecologic Society for Saturday morning, May 10.

The Annual Meeting will begin on Wednesday afternoon, May 7, at the Diplomat Hotel in Hollywood. Scientific sessions will continue through Saturday.

The complete program will be published in the April issue of *The Journal.*

FRIDAY AFTERNOON — MAY 9

SECTION ON COLON AND RECTAL SURGERY

(Co-sponsored by Florida Society of Colon and Rectal Surgeons)
2:00 p.m. to 6:00 p.m.
Shed Roberson, M.D., Daytona Beach
Program Chairman

"Changing Concepts in the Management of Colorectal Cancer," Malcolm Veidenheimer, M.D., President-Elect, American Society of Colon and Rectal Surgeons, and Head, Department of Colon and Rectal Surgery, Lahey Clinic, Boston, Mass.

"Colonoscopy in Perspective 1980 — State of the Art," John Christie, M.D., South Miami.

"Management of Colonic Hemorrhage," Kimber Ward, M.D., Clearwater.

"Colon Cancer, Choice of Operation," Emmet Ferguson, M.D., Jacksonville.

"How I Do It, Management of Pilonidal Disease, Fissure, Fistula, Hemorrhoids" (Panel)

Moderator: William P. Scherer, M.D., Ft. Lauderdale

Participants:

Matt Larkin, M.D., Miami.
Malcolm Veidenheimer, M.D., Boston, Mass.
John Cheleden, M.D., Daytona Beach.

SECTION ON PEDIATRICS AND NUCLEAR MEDICINE

(Co-sponsored by Florida Pediatric Society and Florida Association of Nuclear Physicians)
2:00 p.m. to 6:00 p.m.
Robert H. Threlkel, M.D., Jacksonville
George N. Sfakianakis, M.D., Miami
Program Co-Chairmen

"Ultrasonography in Pediatrics"

Introduction — Aldo Serafini, M.D., Associate Professor, Division of Nuclear Medicine, Department of Radiology, University of Miami School of Medicine, Miami.

"Echocardiography," Pedro L. Ferrer, M.D., Associate Professor of Pediatrics, Division of Pediatric Cardiology, University of Miami School of Medicine, Miami.

"Abdominal Ultrasonography," Jane Frank, M.D., Assistant Professor of Radiology, University of Miami School of Medicine, Miami.

"Nuclear Medicine in Pediatrics," George N. Sfakianakis, M.D., Associate Professor of Radiology, Division of Nuclear Medicine, University of Miami School of Medicine, Miami.

"New Developments in Acute Leukemia in Childhood," Sarah Strandjord, M.D., Division of Hematology and Oncology, Department of Pediatrics, University of Florida College of Medicine, Gainesville.

"New Developments in Pediatric Infectious Diseases," Jack Hutto, M.D., Division of Infectious Diseases and Immunology, All Children's Hospital, St. Petersburg, and Assistant Clinical Professor of Pediatrics, University of South Florida College of Medicine, Tampa.

SATURDAY MORNING — MAY 16

SECTION ON OBSTETRICS AND GYNECOLOGY

(Co-sponsored by Florida Obstetric and Gynecologic Society)
8:00 a.m. to 11:30 a.m.
Eric F. Geiger, M.D., Pensacola
Program Chairman

"Regionalization of Obstetrics in Florida — What Effects (so far) on Mother, Baby and Doctor?"

Welcome and Introductory Remarks — Allan McLeod, M.D., Professor and Vice Chairman, Department of Obstetrics and Gynecology, University of Miami School of Medicine, Miami.

"Newborns — Are They Different Now?" John Curran, M.D., Associate Professor of Pediatrics/Neonatology, University of South Florida College of Medicine, Tampa.

"Recent Changes in the Care of Women During High Risk Pregnancy and Delivery," Amelia C. Cruz, M.D., Associate Professor and Director, Division of Maternal/Fetal Medicine, University of Florida College of Medicine, Gainesville.

"Whither Obstetrics" (A panel discussion with audience participation)

Participants:

Edward J. Quilligan, M.D., Irvine, Calif.
John Curran, M.D., Tampa
Eric F. Geiger, M.D., Pensacola
Mary Jo Sullivan, Director of Maternal-Fetal Medicine, University of Miami School of Medicine and Jackson Memorial Hospital, Miami
Robert A. Knuppel, M.D., M.P.H., Director of Maternal-Fetal Medicine, University of South Florida College of Medicine and Tampa General Hospital, Tampa.

"Contraception," Edward J. Quilligan, M.D., Irvine, Calif.

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Each of the following should begin on a new page: synopsis-abstract, first page of text, legends for illustrations, tables and acknowledgments. Each page should include a running head and surname of senior author.

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Title should be short, specific, clear and amenable to indexing.

List affiliations for each author. If author's present affiliation is different from affiliation under which the work is done, both should be given.

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All accepted manuscripts are subject to copy editing. Authors receive a galley proof for approval before publication. No changes are accepted after galley is returned. Forms for ordering reprints are included with the galley proofs.

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Brief Summary

INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.

CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).

WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle, the patient should therefore be cautioned accordingly. *Drug Dependence.* Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. *Use in Pregnancy:* Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children:* Tenuate is not recommended for use in children under 12 years of age.

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

ADVERSE REACTIONS: *Cardiovascular:* Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System:* Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal:* Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic:* Urticaria, rash, ecchymosis, erythema. *Endocrine:* impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System:* Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous:* A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in midevening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg tablet daily, swallowed whole, in midmorning. Tenuate is not recommended for use in children under 12 years of age.

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Many patients, on the other hand, present with excess fat but no disease. While this condition is often termed uncomplicated obesity, complications of both a social and a psychologic nature may be distressingly real for the patients. In these cases, a short-term regimen of Tenuate can help reinforce your dietary counsel during the important early weeks of an indicated weight loss program.

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The anorectic effectiveness of diethylpropion hydrochloride is well documented. No less than 16 separate double-blind, placebo-controlled studies attest to its usefulness in daily practice.[1] And the unique chemistry of Tenuate provides "...anorectic potency with minimal overt central nervous system or cardiovascular stimulation."[2] Compared with the amphetamines, diethylpropion has minimal potential for abuse.

Tenuate—it makes sense. And it's responsible medicine.

*Studies have shown that obesity is associated with an increased incidence of hypertension, symptomatic heart disease, adult-onset diabetes, and other diseases.

Merrell

For prescribing information see opposite page.

A well-tolerated, nonnarcotic prescription for pain



© 1979 The Upjohn Company

Motrin® now proved an effective analgesic for mild to moderate pain

Motrin 400 mg provided greater relief of pain than did propoxyphene 65 mg in controlled clinical pain studies.

Time after drug administration (hour)		.5	1	2	3	4
Mean relief-of-pain scores* (No. patients reporting)	Motrin 400 mg ibuprofen	.89 (108)	1.25 (108)	1.36 (108)	1.28 (107)	1.19 (106)
	Darvon 65 mg propoxyphene	.66 (100)	.99 (99)	1.13 (96)	.99 (96)	.80 (96)
Statistical significance		$p<0.02$	$p<0.01$	$p<0.05$	$p<0.02$	$p<0.002$

*0 = No relief 1 = Partial relief 2 = Complete relief

Data on file at The Upjohn Company

Motrin demonstrated statistically significant greater relief of pain than did Darvon at all time intervals.

Motrin 400 mg TABLETS
ibuprofen, Upjohn

- Not a narcotic • Not addictive • Not habit forming
- Rapid analgesic action • Indicated in acute and chronic pain
- Well tolerated. The most common side effect with Motrin is mild gastrointestinal disturbance.

Please turn the page for a brief summary of prescribing information.

Upjohn

Motrin® (ibuprofen) now proved an effective analgesic for mild to moderate pain

Motrin® Tablets (ibuprofen, Upjohn)

Indications and Usage: Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in long-term management. Safety and efficacy have not been established in Functional Class IV rheumatoid arthritis.

Relief of mild to moderate pain.

Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS).

Warnings: Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

Drug interactions. *Aspirin:* used concomitantly may decrease Motrin blood levels. *Coumarin:* Bleeding has been reported in patients taking Motrin and coumarin.

Pregnancy and nursing mothers: Motrin should not be taken during pregnancy or by nursing mothers.

Adverse Reactions

Incidence greater than 1%

Gastrointestinal: The most frequent type of adverse reaction occurring with Motrin is gastrointestinal (4% to 16%). This includes nausea,* epigastric pain,* heartburn,* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness,* headache, nervousness. **Dermatologic:** Rash* (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

*Incidence 3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

Dosage and Administration: Rheumatoid and osteoarthritis, including flares of chronic disease: Suggested dosage is 300, 400 or 600 mg t.i.d. or q.i.d.
Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for relief of pain.

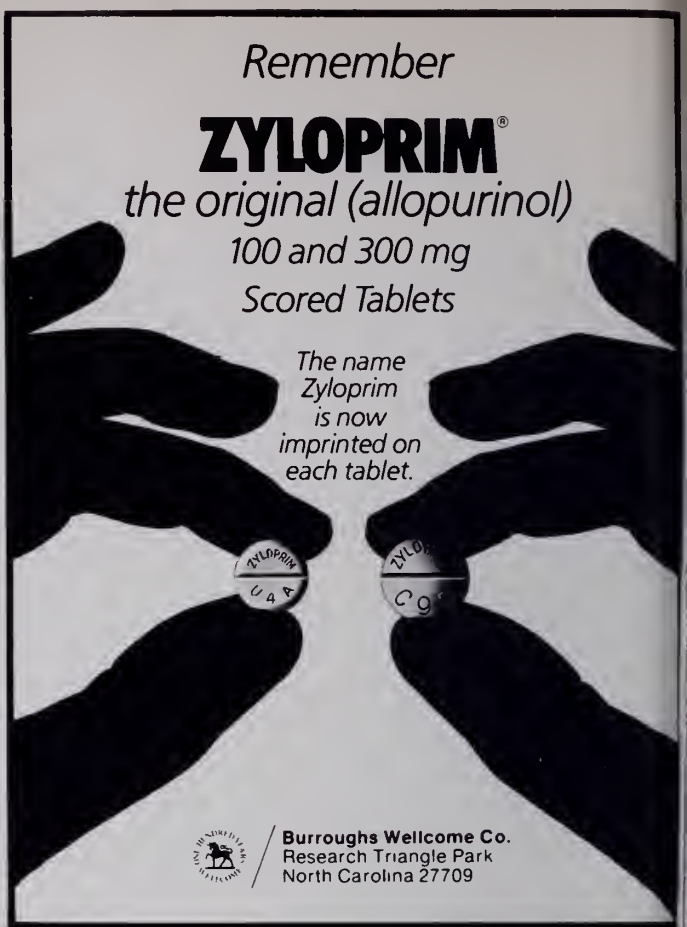
Do not exceed 2400 mg per day.

Caution: Federal law prohibits dispensing without prescription.

For additional product information, see your Upjohn representative or consult the package insert.

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Book Reviews

Book Review Editor
F. Norman Vickers, M.D.

Instructions For Parents by Matthew M. Cohen, M.D. 232 Pages. Price $22.50. Appleton-Century-Crofts, New York 1979.

Dr. Cohen's book is unusual in that the title is exactly what this book is all about. First and foremost, it lists a broad gamut of pediatric problems under 110 separate two or three page chapters. The book is arranged in loose-leaf, cookbook, straight-forward style. Despite the brevity of its chapters, they provide a surprising amount of anxiety lessening information for the parent. Subjects such as newborn care, growth and development, common childhood illnesses, safety, accidents and prevention, and habits and behavior are followed by a short reference list for those who desire more detailed reading. The book is designed so that a section or chapter can be easily photocopied and handed out as instruction sheet or supplement for answering common questions about the illness and what should be done. Whether or not this is enticement enough for pediatricians and family practitioners to buy this text is questionable. As a non-pediatrician and parent, I find there are several chapters which answer occasional questions which periodically occur without the necessity of calling our pediatrician. The book seems aimed at the parents and in this regard is complete without being voluminous. It is not a treatise on diagnosis and therapy or a textbook for students. Neither is it a compendium of the author's personal opinions.

Michael P. Flynn, M.D.
Tampa

Dr. Flynn practices Radiology in Tampa.

Principles of Clinical Electrocardiography, 10th Edition, by M. J. Goldman. 415 Pages. Price $12.00. Lange Medical Publication, Los Altos, California 94022.

Principles of Clinical Electrocardiography belongs to that handful of classic primers whose sustained popularity has resulted in numerous successful editions and translations into several languages.

Originally copyrighted in 1956, I can recall studying an early edition in medical school.

Although concepts have continued to change, the format has remained recognizable with numerous electrocardiographic examples, clear diagrams (simplistic to facilitate learning), and a succinct, pointed text.

Appropriate clinical correlations are included in major entity discussions and the practical usefulness of this volume has not paled over the years. The use of italics, bold-face type and subheadings in outline format complements the illustrative material very well. Revised secton in this Tenth Edition include exercise testing and pre-excitation syndromes. One of the most lucid presentations of spatial vectorocardiography and its clear relationship to planar tracings to be found anywhere continues to be a highlight of the volume. Unfortunately, most of the reference articles in the bibliography are more than six years old, but many classical studies are listed.

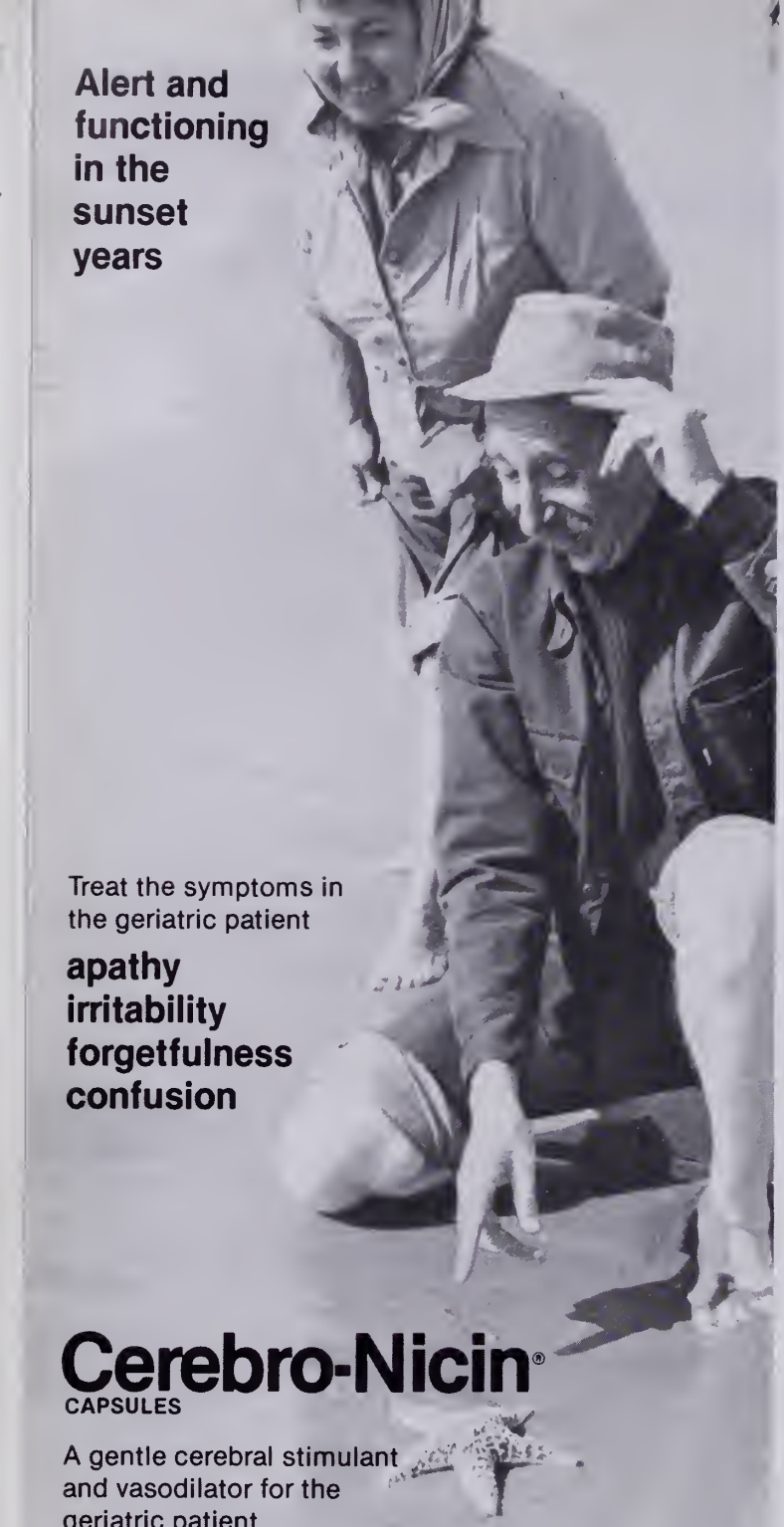
The book that introduced many of us to electrocardiography remains alive and well, recognizable and still helpful as old friends should be.

Harry Eichenbaum, M.D.
St. Petersburg

Dr. Eichenbaum is in the private practice of Internal Medicine in St. Petersburg.

That which is unique and worthwhile in us makes itself felt only in flashes. If we do not know how to catch and savor these flashes, we are without growth and without exhilaration.

Eric Hoffer



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INDICATIONS: As a cerebral stimulant and vasodilator.

RECOMMENDED GERIATRIC DOSAGE: One capsule three times daily adjusted to the individual patient.

WARNING: Overdosage may cause muscle tremor and convulsions.

CONTRAINDICATIONS: Epilepsy or low convulsive threshold.

CAUTION: Federal law prohibits dispensing without prescription. Keep out of reach of children.

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Books Received

Receipt of the following books is acknowledged. Medical readers interested in reviewing particular books are invited to address requests to the Book Review Editor. Following acceptance of a written review for publication, a reviewer may then retain the book reviewed for his personal or favorite library.

The Chemistry of Human Behavior by Herbert L. Meltzer, Ph.D. 261 Pages. Illustrated. Price $17.95 (cloth). Nelson-Hall Publishers, Chicago, 1979.

Annual Review of Neuroscience with 31 contributing authors. 555 Pages. Annual Reviews, Inc., Palo Alto, California, 1979.

Norethindrone, The First Three Decades edited by Mary Jean Pramik. 100 Pages. Syntex Laboratories, Palo Alto, California, 1978.

Family Health in an Era of Stress conducted by Yankelovich, Skelly and White, Inc. 192 Pages (plus packet). General Mills, Inc., Minneapolis, Minnesota, 1979.

Correlative Neuroanatomy & Functional Neurology, 17th Edition, by Joseph G. Chusid, M.D. 464 Pages. Illustrated. Price $12.00. Lange Medical Publications, Los Altos, California, 1979.

Review of Allied Health Education: 3, Joseph Hamburg, General Editor. 161 Pages. Price $7.50. The University Press of Kentucky, Lexington, Ky., 1979.

Family Health and Home Nursing, American National Red Cross. 626 Pages. Illustrated. Price $3.95. Doubleday & Company, Inc., New York, 1979.

Review of Medical Physiology, 9th Edition, by William F. Ganong, M.D. 618 Pages. Illustrated. $14.00. Lange Medical Publications, Los Altos, California, 1979.

How To Improve Your Child's Behavior Through Diet by Laura J. Stevens and Rosemary B. Stoner. 346 Pages. Price $9.95. Doubleday & Company, Inc., New York, 1979.

Helping Hospital Trustees Understand Physicians by Richard E. Thompson, M.D. 82 Pages. Price $9.00. American Hospital Association, Chicago.

Child Guidance by Samuel Kahn, M.D., Ph.D., F.R.S.H. 134 Pages. Price $10.00. Philosophical Library, Inc., New York, 1979.

Current Surgical Diagnosis and Treatment, Fourth Edition by J. Englebert Dunphy, M.D., and Lawrence W. Way, M.D. 1162 Pages. Price $19.00. Lange Medical Publications, Los Altos, California, 1979.

The Vitamin Book by Rich Wentzler. 224 Pages. Price $4.95. Doubleday & Company, Inc., New York, 1979.

The Truth About Senility — And How To Avoid It by Lawrence Galton. 244 Pages. Price $9.95. Thomas Y. Crowell Company, New York, 1979.

Drug Induced Nutritional Deficiencies by Daphne A. Roe, M.D. 272 Pages. The Avi Publishing Company, Inc., Westport, Connecticut, 1978.

Alcohol and the Diet by Daphne A. Roe, M.D. 229 Pages. The Avi Publishing Company, Inc., Westport, Connecticut, 1979.

Cooking Creatively for Your Diabetic Child by Caroline Hastings Babington. 224 Pages. Price $8.95. Doubleday & Company, Inc., New York, 1979.

Applied Therapeutics for Clinical Pharmacists, Second Edition, Edited by Mary Anne Koda-Kimble, Pharm. D., Brian S. Katcher, Pharm. D., and Lloyd Y. Young, Pharm. D. 944 Pages. Price $31.50. Applied Therapeutics, Inc., San Francisco, 1978.

Review of Physiological Chemistry by Harold A. Harper, Ph.D., Victor W. Rodwell, Ph.D., and Peter A. Mayes, Ph.D., D. Sc. 792 Pages. Price $14.50. Lange Medical Publications, Los Altos, California, 1977.

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Riboflavin (B-2).....2 mg.
Pyridoxine HCL (B-6) .....10 mg.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500.

LIPO-NICIN®/100 mg.
Each blue tablet contains:
Nicotinic Acid .....100 mg.
Niacinamide.....75 mg.
Ascorbic Acid.....150 mg.
Thiamine HCL (B-1) .....25 mg.
Riboflavin (B-2).....2 mg.
Pyridoxine HCL (B-6) .....10 mg.
DOSE: 1 to 5 tablets daily.
AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN® 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient.

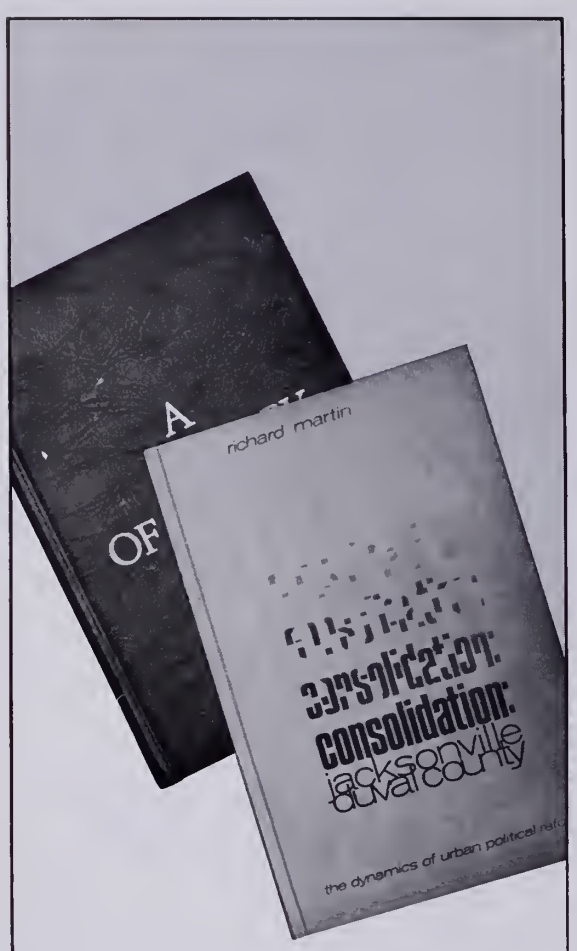
Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur.

Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

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Brief Summary of Prescribing Information

Indications and Usage: Symptomatic relief of anxiety, tension, agitation, irritability a insomnia associated with anxiety neuroses and transient situational disturbances; anxi associated with depressive symptoms and as a treatment of symptoms of anxiety if such sym toms are a significant feature of functional or organic disorders, particularly gastrointestinal cardiovascular

Effectiveness in long-term use, i e., more than 4 months, has not been assessed by syste atic clinical studies Reassess periodically usefulness of the drug for the individual patient.

Contraindications: Known sensitivity to benzodiazepines or acute narrow-angle glaucoma

Warnings: Not recommended in primary depressive disorders or psychoses. As with all CN acting drugs, warn patients on lorazepam not to operate machinery or motor vehicles, and diminished tolerance for alcohol and other CNS depressants

Physical and Psychological Dependence Withdrawal symptoms like those noted with bar turates and alcohol have occurred following abrupt discontinuance of benzodiazepir (including convulsions, tremor, abdominal and muscle cramps, vomiting and sweating) Add tion-prone individuals, e g drug addicts and alcoholics, should be under careful surveillar when on benzodiazepines because of their predisposition to habituation and dependen Withdrawal symptoms have also been reported following abrupt discontinuance of benzo azepines taken continuously at therapeutic levels for several months

Precautions: In depression accompanying anxiety, consider possibility for suicide

For elderly or debilitated patients, initial daily dosage should not exceed 2mg to avoid ov sedation

Terminate dosage gradually since abrupt withdrawal of any antianxiety agent may resul symptoms like those being treated. anxiety, agitation, irritability, tension, insomnia and oc sional convulsions

Observe usual precautions with impaired renal or hepatic function

Where gastrointestinal or cardiovascular disorders coexist with anxiety, note that lorazep has not been shown of significant benefit in treating gastrointestinal or cardiovascular com nent

Esophageal dilation occurred in rats treated with lorazepam for more than 1 year 6mg kg day No effect dose was 1 25mg/kg/day (approximately 6 times the maximum hum therapeutic dose of 10mg/day) Effect was reversible only when treatment was withdrawn wit 2 months of first observation Clinical significance is unknown, but use of lorazepam for p longed periods and in geriatric patients requires caution and frequent monitoring for sympto of upper G I disease

Safety and effectiveness in children under 12 years have not been established

ESSENTIAL LABORATORY TESTS Some patients have developed leukopenia, some have l elevations of LDH As with other benzodiazepines, periodic blood counts and liver function te are recommended during long-term therapy

CLINICALLY SIGNIFICANT DRUG INTERACTIONS Benzodiazepines produce CNS depress effects when administered with such medications as barbiturates or alcohol.

CARCINOGENESIS AND MUTAGENESIS No evidence of carcinogenic potential emerge rats during an 18-month study No studies regarding mutagenesis have been performed.

PREGNANCY Reproductive studies were performed in mice, rats, and 2 strains of rabt Occasional anomalies (reduction of tarsals, tibia, metatarsals, malrotated limbs, gastrosch malformed skull and microphthalmia) were seen in drug-treated rabbits without relationshi dosage Although all these anomalies were not present in the concurrent control group, t have been reported to occur randomly in historical controls At 40mg/kg and higher, there evidence of fetal resorption and increased fetal loss in rabbits which was not seen at lo doses Clinical significance of these findings is not known. However, increased risk of cong tal malformations associated with use of minor tranquilizers (chlordiazepoxide, diazepam meprobamate) during first trimester of pregnancy has been suggested in several stud Because use of these drugs is rarely a matter of urgency, use of lorazepam during this pe should almost always be avoided Possibility that a woman of child-bearing potential may pregnant at institution of therapy should be considered. Advise patients if they become pr nant to communicate with their physician about desirability of discontinuing the drug.

In humans, blood levels from umbilical cord blood indicate placental transfer of lorazep and its glucuronide

NURSING MOTHERS It is not known if oral lorazepam is excreted in human milk like ot benzodiazepines As a general rule, nursing should not be undertaken while on a drug si many drugs are excreted in milk

Adverse Reactions, if they occur, are usually observed at beginning of therapy and gener disappear on continued medication or on decreasing dose In a sample of about 3,500 anxi patients, most frequent adverse reaction is sedation (15 9%), followed by dizziness (6 9 weakness (4 2%) and unsteadiness (3 4%) Less frequent are disorientation, depression, n sea change in appetite, headache, sleep disturbance, agitation, dermatological symptoms, function disturbance, various gastrointestinal symptoms and autonomic manifestations I dence of sedation and unsteadiness increased with age. Small decreases in blood press have been noted but are not clinically significant, probably being related to relief of anxiety.

Overdosage: In management of overdosage with any drug, bear in mind that multiple age may have been taken Manifestations of overdosage include somnolence, confusion and co Induce vomiting and/or undertake gastric lavage followed by general supportive care, moni ing of vital signs and close observation. Hypotension, though unlikely, usually may be contro with Levarterenol Bitartrate Injection U S P Usefulness of dialysis has not been determined

Ativan® (IV) for (lorazepam) Anxiety

Dosage: **Individualize for maximum beneficial effects. Increase dc gradually when needed, giving higher evening dose before increasi daytime doses. Anxiety, usually 2-3mg/day given b.i.d. or t.i.d.; dosa may vary from 1 to 10mg/day in divided doses. For elderly or deb tated, initially 1-2mg/day; insomnia due to anxiety or transient situ tional stress, 2-4mg h.s.**

How Supplied: **0.5, 1.0 and 2.0mg tablets.**

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Philadelphia, PA 19101

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Why one benzodiazepine and not another?

Are you concerned about long-acting metabolites? Many clinicians, as well as pharmacologists, are beginning to draw attention to this problem (see New England Journal of Medicine, April 5, 1979).

In contrast to some older benzodiazepines, Ativan (lorazepam) does not give rise to long-lasting active metabolites. As with all benzodiazepines, you should follow the usual precautions concerning co-administration with other CNS depressants and warn your patients against operating dangerous machinery and motor vehicles.

However, it is noteworthy that Ativan showed no clinical evidence of accumulation even when given in high doses over periods up to 6 months. The half-life of free lorazepam is about 12 hours; steady-state serum levels are attained in 2-3 days. Comparable data for diazepam: 20-50 hours and at least 7-10 days. (The pharmacokinetic profile of a drug can define such characteristics as absorption, distribution, metabolism and elimination but cannot, at present, be directly related to its therapeutic effectiveness.)

Ativan has a convenient b.i.d. or t.i.d. dosage schedule; it is compatible with a long list of other medications and, of course, it is a highly effective anxiolytic agent, as established in numerous nationwide, double-blind, controlled evaluations in thousands of patients.



See important information on preceding page.

Ativan® (lorazepam) for Anxiety

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Others Are Saying

When I first entered private practice some seven years ago, I had the usual and customary rude awakening as to the cost of health care. Having trained in a large municipal hospital I had very little knowledge of the cost of laboratory tests or commonly prescribed drugs. A survey of physicians today continues to show a serious lack of knowledge about the charges for the things they commonly order.

While we as physicians receive less than one-fifth of the health care dollar, our combined actions determine the spending of another three-fifths of that dollar through hospitalization, surgery, prescription drugs, laboratory and x-ray studies, and a myriad of other therapies.

The greatest single portion of the health care dollar goes to hospitals and herein lies the greatest potential for cost containment. In curbing the increase in hospital charges, the most promising avenue appears to be raising the cost consciousness of the physicians.

The hospital cost to a patient undergoing an outpatient D&C exceeds $500. A one day in-hospital stay for the same procedure approaches $1,000. Do you have any idea what a CBC, urinalysis, and VDRL cost your patient? Would you believe approximately $50?

The daily bed-rate has assumed the role of a loss leader. Today, laboratory and drug costs determine the excessive bills our patients are receiving. Physicians must involve themselves with this aspect of medical care. We are entitled to "charge manuals" from our respective hospitals. Likewise, we should insist upon receiving periodic summaries of our patients' hospital bills in the hopes to determine what charges might be eliminated in future admissions without affecting the quality of our care.

We must stop accepting the brunt of the blame for skyrocketing health care costs. We can and must investigate and control the cost of hospitalization.

Phillip A. Caruso, M.D.
President-Elect
Broward County Medical
Association

Reprinted from "The President's Page," The Record, Broward County Medical Association Bulletin, November 1979.

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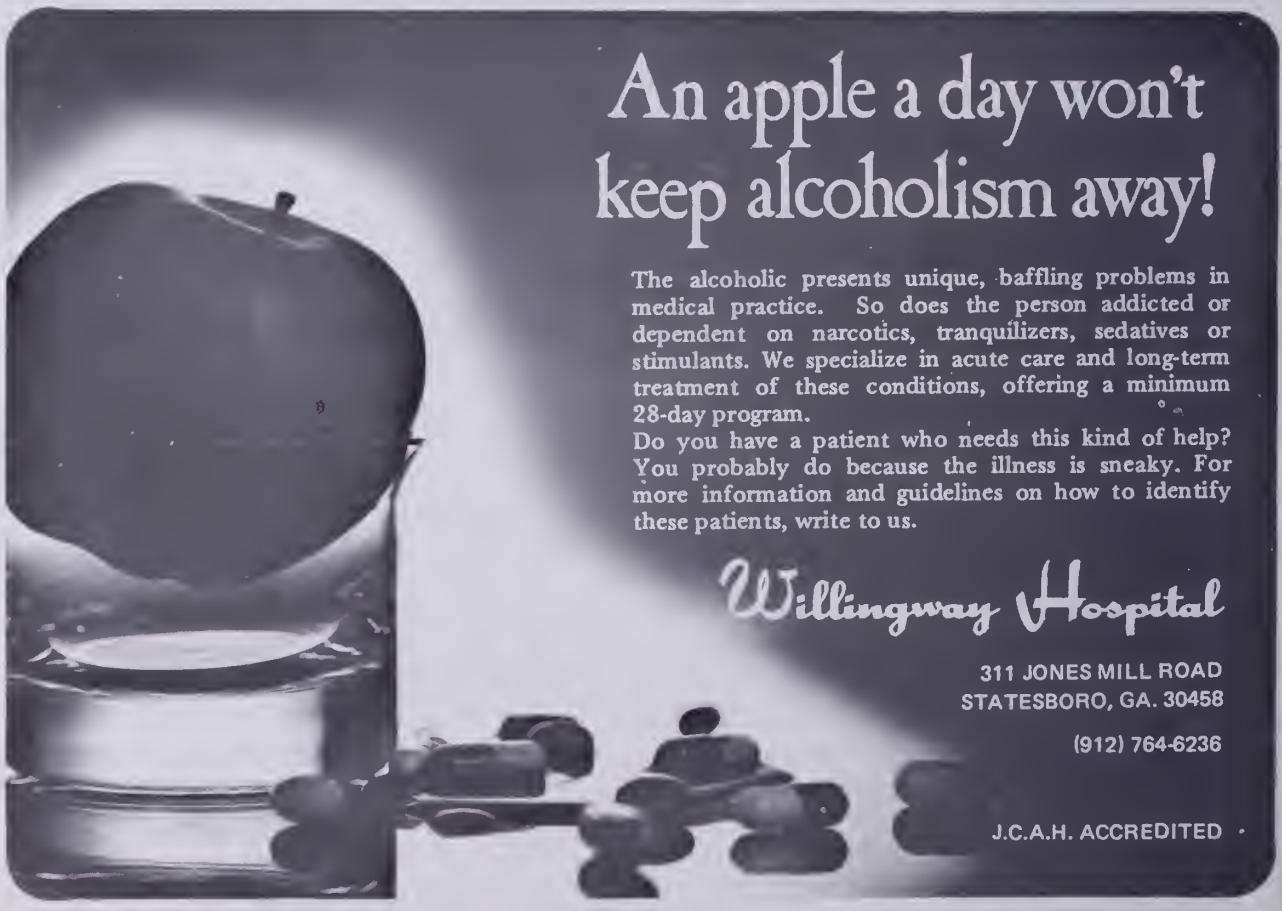
SIDE EFFECTS: Occasionally flushing and pruritus associated with niacin administration.

PRECAUTIONS: Use with caution in patients with low convulsive threshold, focal brain lesions, severely impaired liver function, peptic ulcer, diabetes, and gall bladder or liver diseases. Niacin may potentiate hypotensive drugs, phenothiazine derivatives and inactivate fibrinolysin.

CONTRAINDICATIONS: There are no known contraindications to Menic.

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J.C.A.H. ACCREDITED



A. Joseph Henry Jr., M.D., of Tallahasee . . . has been elected Chairman of Florida's Community Hospital Education Council (CHEC).

Dr. Henry has been a member of CHEC since 1972 and is a Diplomate of the American Board of Family Practice. He was elected at the Council's meeting in Tampa on January 14 to succeed **Charles J. Kahn, M.D.**, of Pensacola, who has held the post for four years.

Dr. Kahn will remain a member of CHEC.

Twenty-five Florida physicians . . . have been admitted as Fellows of the American College of Chest Physicians.

The new group of Fellows was admitted at the ACCP's Annual Scientific Assembly in Houston, Texas, last November. The Fellowship Pledge included an addendum in which the new members stated their intention to join a campaign against smoking.

Florida Fellows include:

Drs. Horst Baier, Alex J. Furst, Leonardo V. Lopez, and **Rolando C. Mendizabal,** all of Miami; **Edward B. Bolton Jr., Ing-Sei Hwang,** and **Ronald J. Scott,** all of Fort Lauderdale; **Philip G. Boysen, Daniel G. Knauf,** and **John H. Selby;** all of Gainesville; and **Rahim Salari-Lak** and **Russell M. Stewart III,** both of Lakeland.

Drs. Paul F. Eckstein, Larry J. Foster, Benedict S. Maniscalco, and **Howard M. Robbins,** all of Tampa; **Carlos M. Estevez** of St. Petersburg; **Jose F. Font** of Hialiah; **Jose F. Landa** of Miami Beach; **Michael S. Marek** of Hollywood; **Geoffrey A. O'Malley** of Tallahassee; **Vinad M. Patel** of Plantation; **Arthur E. Pitchenik** of North Miami Beach; **Meredith L. Scott** of Orlando; and **Peter M. Sidell** of Fort Myers.

William R. Richardson, M.D. . . . has been appointed Professor and Director of the Division of Pediatric Surgery at the University of South Florida College of Medicine. A graduate of Harvard Medical School, Dr. Richardson comes to Tampa from Cincinnati, Ohio, where he had been in private practice and was Clinical Associate Professor of Surgery at the University of Cincinnati since 1965.

Prior to moving to Cincinnati, Dr. Richardson was assocated with Harvard Medical School, the Medical College of Alabama, State University of New York College of Medicine, and the University of Oklahoma Medical School.

Dr. Richardson is certified by the American Board of Surgery in pediatric surgery.

The University of South Florida also announced the appointment of **Robert A. Callahan, M.D.**, as Assistant Professor of Orthopedic Surgery. Dr. Callahan had held a similar appointment at the University of Miami School of Medicine.

Melvin L. Rubin, M.D., of Gainesville . . . has been re-elected Secretary for Instruction of the American Academy of Ophthalmology. Dr. Rubin is Professor and Chairman of the Department of Ophthalmology of the University of Florida College of Medicine.

Robert A. Gunn, M.D., M.P.H. . . . has been named State Epidemiologist with Florida's Health Program Office. A native of New York, Dr. Gunn is a graduate of the Yale University College of Medicine, Class of 1966.

Immediately prior to his appointment, Dr. Gunn was on the staff of the Center for Disease Control in Atlanta.

Allan L. Armstrong, M.D., of Tampa . . . was among six physicians to win an award in the 1979 Kodak International Newspaper Snapshot Awards. He received a Kodak Centennial Medallion for excellence in amateur photography.

Dr. Armstrong photographed a lantern near a shop entrance in Massachusetts.

Seven Florida physicians . . . are among the latest group of 100 physicians and surgeons nationally to be named to Fellowship in the American College of Cardiology.

The Floridians were listed as: **Danton N. DeGuia, M.D.**, Englewood; **Thomas Feistmann, M.D.**, West Palm Beach; **Michael D. Ozner, M.D.**, and **John Sokolowicz, M.D.**, Miami; **Yale M. Samole, M.D.**, Coral Gables; **Peter M. Sidell, M.D.**, Fort Myers; and **David S. Spector, M.D.**, Orlando.

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Product Information as of September, 1977

U.S. Patent 2,985,558

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MEETINGS

Approved by the FMA Committee on Continuing Medical Education

APRIL

Diagnostic Therapeutics XVIX — Ophthalmology: Extracapsular Cataract Surgery and Implants, Apr. 5-6, Doctors' Club & Study Center, The Hilton Inn & Conference Center at Inverrary, Ft. Lauderdale. For information: Doctors's Club, The Hilton Inn & Conference Center at Inverrary, 3501 Inverrary Blvd., Suite 106, Ft. Lauderdale 33319.

Lumbar Spine Surgery Seminar — 1980, Apr. 5-6, The Gainesville Hilton Inn, Gainesville. For Information: JFMA, Hazel Sessions, Box NFR, Gainesville 32602.

Skin Cancer: Recognition, Pathology and Treatment of Squamous and Basal Cell Cancer, Apr. 8, Victoria Hospital, Miami.*

The Clinical Approach to Exercise Testing, Apr. 10-12, Sheraton Sand Key, Clearwater. +

Faculty Development for Community Physicians, Apr. 11-12, Family Practice Clinic, Gainesville. For information: Lynn Carmichael, M.D., Box 016700, Miami 33101.

Second Annual Holmes Regional Medical Center Symposium Trauma, Apr. 11-12, Holmes Regional Medical Center, Melbourne. For information: Pat B. Unger, M.D., 1281 S. Hickory St., Melbourne 32901.

Cardiac Rehabilitation, Apr. 11-13, Hyatt House, Orlando. For information: International Medical Education Corp., Div. of Postgraduate Education, Dept. 12, 64 Inverness Dr. E., Englewood, CA 80112.

Faculty Development for Community Physicians, Apr. 15-16, Florida Hospital, Orlando. For information: Lynn Carmichael, M.D., Box 016700, Miami 33101.

Lymphomas, Apr. 17, Doctors Hospital of Hollywood, Hollywood. For information: Peter W. A. Mansell, M.D., Comprehensive Cancer Center, Box 016960, Miami 33101.

***For information: Contact Division of Continuing Medical Education, D23-3, University of Miami School of Medicine, P.O. Box 016960, Miami 33101. Tel. (305) 547-6716.**

****For information: Contact Division of Continuing Education, Box J-233, J. Hillis Miller Health Center, Gainesville 32610. Tel. (904) 392-3143, or 392-3183.**

+For information: Contact Janifer M. Judisch, M.D., CME, University of South Florida, Tampa 33620. Tel. (813) 974-2196.

Faculty Development for Community Physicians, Apr. 17-18, Halifax Hospital Medical Center, Daytona Beach. For information: Lynn Carmichael, M.D., Box 016700, Miami 33101.

Gastroenterology Today: For the Clinician, Apr. 18-20, Orlando Marriott Inn, Orlando.**

New Techniques in Temporal Bone Surgery, Apr. 18-20, Holiday Inn, Longboat Key. For information: Sarasota County Medical Society, 1845 Hillview St., Sarasota 33579.

Family Practice Weekend, University of Florida, Apr. 19, Gainesville Hilton, Gainesville. For information: E. Scott Medley, M.D., 625 Southwest Fourth Ave., Gainesville 32601.

Echocardiography In-Service Workshop, Apr. 21-25, Jackson Memorial Medical Center, Miami.*

Holistic Medicine — 21st Century Medicine, Apr. 23, Humanities Auditorium, Daytona Beach Community College, Daytona Beach. For information: Mrs. Jackie Harrison, Health Service Clinic Director, Box 1111, Daytona Beach 32015.

Endocrinology and Diabetes '80, Apr. 25-26, Dutch Inn, Lake Buena Vista. For information: Barry E. Sieger, M.D., Director of Medical Education, Orlando Regional Medical Center, 1414 South Kuhl Ave., Orlando 32806.

8th Annual Intensive Care Symposium, Apr. 25-28, Eden Roc Hotel, Miami Beach.*

Update on Inhalation Anesthesia—Progress and Concepts of the Past Decade, Apr. 26-27, Marriott Hotel, New Orleans, LA. For information: Warren W. Sears, M.D., 1717 North E Street, Suite 205, Pensacola 32501.

MAY

Pediatric Ophthalmology, May 1-3, Don CeSar Hotel, St. Petersburg Beach.+

Principles of Cosmetics for the Dermatologist: 1980, May 1-3, Omni International Hotel, Miami. For information: Ms. Esther Cohen, CME Coordinator, Mt. Sinai Medical Center, 4300 Alton Rd., Miami Beach 33140.

Update on Hormone Replacement, May 12, Citrus Memorial Hospital, Inverness. For information: R. Edward Dodge Jr., M.D., 511 W. Highland Blvd., Inverness 32650.

Designing A Program for the Management of Arthritis, May 13, Manatee Memorial Hospital Auditorium, Bradenton. For information: Leonides Y. Teves, M.D. 706 39th St., W., Bradenton 33505.

Recent Advances in Endocrinology, May 15-17, Hilton Hotel, Jacksonville. For information: Ms. Sheila Reed, CME Coord., JHEP, 655 W. 8th St., Jacksonville 32209.

A Symposium: Refracting and Prescribing (Ophthalmology), May 16, Gainesville Hilton, Gainesville.**

Seminar on Hypertension and Renal Disease (in Spanish), May 16-17, Konover Hotel, Miami Beach.*

Nuclear Medicine and Radioassay Training Seminar, May 26-30, Miami.*

Master Approach to Cardiovascular Problems — 8th Annual Conference, May 30-June 1, Contemporary Hotel, Disney World, Lake Buena Vista. For information: Yolanda Barcena, Department of Cardiology, P.O. Box 016960, Miami 33101.

JUNE

Bascom Palmer Eye Institute, Resident's Day, June, Miami.*

Annual Homecoming in Psychiatry, June, Miami.*

Cardiology for the Practitioner, June 4-6, The Breakers, Palm Beach.**

Fifth Annual Florida Suncoast Pediatric Conference, June 15-18, Sheraton Sand Key Hotel, Clearwater. For information: Donald I. Macdonald, M.D., 801 Sixth St., S., St. Petersburg 33701.

MKSAP-V (Internal Medicine Review) (American College of Physicians), June 23-27, The Dutch Inn, Lake Buena Vista.**

JULY

Coronary Disease, Exercise Teastin, and Cardiac Rehabilitation, July 11-13, Orlando Hyatt, Orlando. For information: International Medical Education Corp., Division of Postgraduate Education, Dept. 12, 64 Inverness Dr., E., Englewood, Colorado 80112.

Ventricular Arrhythmias, July 14, Citrus Memorial Hospital, Inverness. For information: R. Edward Dodge Jr., M.D., 511 W. Highland Blvd., Inverness 32650.

5th Canadian Summer Workshop in EKG, July 19-22, Edmonton, Alberta, Canada, For information: Henry J. L. Marriott, M.D., Rogers Heart Foundation, St. Anthony's Hospital, St. Petersburg 33705.

Dermatopathology Seminar and Slide Conference, July 26-27, Breaker's Hotel, Palm Beach. For information: C. Fenner McConnell, M.D., 5151 N. 9th Ave., Pensacola 32504.

AUGUST

Fundamental and Clinical Aspects of Internal Medicine, Aug. 1980.*

EKG Interpretation and Arrhythmia Management, Aug. 22-24, Dutch Inn, Lake Buena Vista. For information: International Medical Education Corp., Division of Postgraduate Education, Dept. 12, 64 Inverness Dr., E., Englewood, Colorado 80112.

18th Annual Seminar in Cardiology, Aug. 30-Sept. 6, Copenhagen, Denmark. For information: Henry J. L. Marriott, M.D., Rogers Heart Foundation. St. Anthony's Hospital, St. Petersburg 33705.

SEPTEMBER

Dermatology in Florida, Sept. 8, Citrus Memorial Hospital, Inverness. For information: R Edward Dodge Jr., M.D., 511 W. Highland Blvd., Inverness 32650.

OCTOBER

Echocardiography In-Service Workshop, Oct. 20-24, University of Miami, Jackson Memorial Medical Center, Miami.*

21st Workshop in EKG for Nurses and Physicians, Oct. 30-Nov. 3, Sheraton Sand Key Hotel, Clearwater Beach. For information: Henry J. L. Mariott, M.D., St. Anthony's Hospital, St. Petersburg 33705.

NOVEMBER

Vascular Lesion of CNS, Nov. 10, Citrus Memorial Hospital, Inverness. For information: R. Edward Dodge Jr., M.D., 511 W. Highland Blvd., Inverness 32650.

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Mount Sinai
MEDICAL CENTER OF GREATER MIAMI
4300 Alton Road, Miami Beach, Florida 33140

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Wednesday
April 30, 1980

"MEDICAL AND CARDIOVASCULAR PROBLEMS IN ORTHOPAEDICS"

8:00 a.m. — 1:00 p.m.

Wolfson Auditorium, Mount Sinai Medical Center of Greater Miami, 4300 Alton Rd., Miami Beach, FL 33140

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Mount Sinai Medical Center

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COURSE DESCRIPTION

Frequently, a medical patient develops an orthopaedic problem just as orthopaedic patients develop medical complications. Concommittent care by the orthopaedic surgeon and the family practice physician, internist and cardiologist indicate the need of cooperation as well as knowledge of each other's medical fields. The purpose of this seminar is to present and mutually discuss medical and orthopaedic problems, many of which have cardiovascular complications. The combined efforts of the specialists to clarify the diagnosis and institute the most effective treatment will be presented at this seminar.

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Registration Fee: $50.

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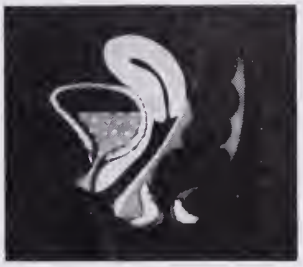
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Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

Pneumocystis carinii pneumonitis: Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets,* each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. *Tablets,* each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. *Oral suspension,* containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

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SPECIAL ISSUE ON PHYSICAL FITNESS

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James B. Perry, M.D.

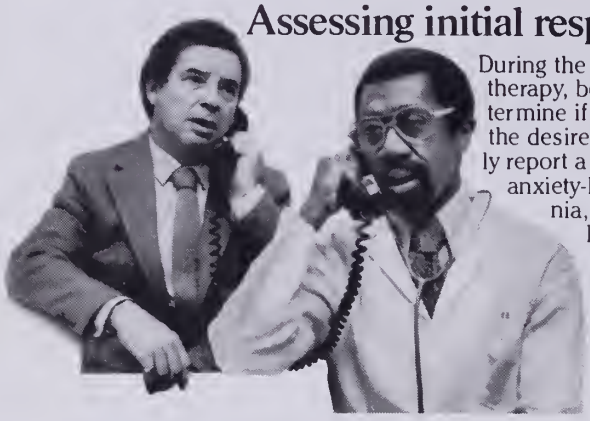
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SEE FMA AUXILIARY BEEPER, PAGE 354a

Aspects of management

Monitoring patient response to Valium® (diazepam/Roche)

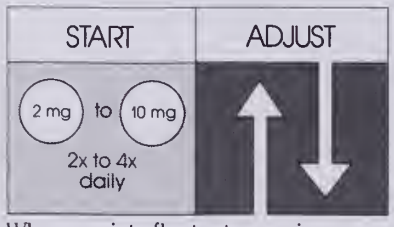


Assessing initial response to therapy

During the first follow-up visit after initiating therapy, both physician and patient should determine if Valium (diazepam/Roche) is having the desired effect. Most patients will promptly report a feeling of relaxation and relief of anxiety-linked symptoms such as insomnia, headaches, palpitations and hyperventilation. You will probably observe that the patient is calmer and more relaxed. If, however, patient response does not measure up to expectations, a reevaluation of the patient's profile with modification of the dosage regimen should be considered.



Making dosage adjustments



With any psychoactive medication it is good medical practice to initiate therapy at base dosage levels and titrate to the patient's needs. With Valium, experience has shown that 5 mg t.i.d. is usually sufficient although some patients with severe or persistent anxiety may require higher dosages initially. In geriatric or debilitated patients, the recommended dosage is 2 to 2½ mg once or twice daily. When anxiety fluctuates, as is common with most patients, the dosage may be adjusted as needed during the course of therapy; three strengths in scored tablets give you unmatched flexibility and simplicity in individualizing dosage.

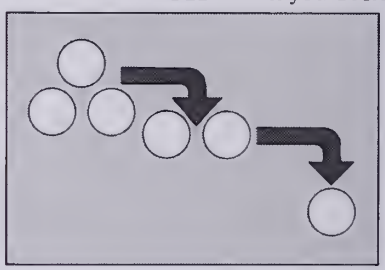
Evaluating progress toward therapeutic goals

SET GOALS						
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

At the beginning of therapy it is now common practice for both physician and patient to establish treatment goals and to estimate the amount of time needed to achieve them. Then the patient knows what to expect and when to expect it. Some physicians find that compiling a checklist of presenting symptoms and complaints is useful for assessing the patient's response from visit to visit. In this way, progress toward attainment of the therapeutic goal is reviewed at regular intervals. As patients feel their symptoms abate and begin to develop insight into the sources of their anxiety and psychic tension, the checklist can be expected to dwindle.

Discontinuing pharmacologic intervention

When you decide to discontinue therapy, tapering dosag is good medical practic Although rarely necessary after short-term treatment with Valium, gradual dosage reducti is advisable for patients who have been on extended therapy. This gra ual discontinuance should preclude either recurrence of pretreatment symptoms or development of untoward side effects. Symptoms of withdrawal have almost al ways been associated with abrupt discontinuance of therapy higher dosages taken continuously over long periods of time



2-mg, 5-mg, 10-mg scored tablets

Valium® (IV)
diazepam/Roche

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See the following page for a summary of product information.

Valium®(diazepam/Roche) Ⓥ

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Tension and anxiety associated with anxiety disorders, transient situational disturbances and functional or organic disorders, psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal, adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis; stiff-man syndrome, convulsive disorders (not for sole therapy).
The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.
Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.
Dosage: Individualize for maximum beneficial effect. *Adults.* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).
Supplied: Valium® Tablets, 2 mg, 5 mg and 10 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available in trays of 10.

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We are deeply grateful to Dr. James B. Perry, Dr. Rufus K. Broadaway and all of the contributing authors for bringing this special issue to our readers, highlighting the theme of physical fitness.
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On the Cover

The cover, a collage of the many aspects of physical fitness, was created by John Gandour, a freelance artist currently under contract for Fiesta Magazine on the Gold Coast. Mr. Gandour is a commission artist who has created illustrations for magazines, how-to books and has been shown in some galleries. He lives in Boca Raton, and is a graduate of the Fort Lauderdale Institute of Art.

SPECIAL ISSUE

On Physical Fitness

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CONTRAINDICATIONS Use in Newborn or Premature Infants: This drug should not be used in newborn or premature infants.

Use in Nursing Mothers: Because of the higher risk of antihistamines for infants generally and for newborns and prematures in particular, antihistamine therapy is contraindicated in nursing mothers.

Use in Lower Respiratory Disease: Antihistamines should NOT be used to treat lower respiratory tract symptoms including asthma.

Antihistamines are also contraindicated in the following conditions: hypersensitivity to azatadine maleate and other antihistamines of similar chemical structure; monoamine oxidase inhibitor therapy (See DRUG INTERACTIONS Section).

WARNINGS Antihistamines should be used with considerable caution in patients with: narrow angle glaucoma, stenosing peptic ulcer; pyloroduodenal obstruction; symptomatic prostatic hypertrophy; bladder neck obstruction.

Use in Children: In infants and children especially, antihistamines in overdosage may cause hallucinations, convulsions, or death.

As in adults, antihistamines may diminish mental alertness in children. In the young child, particularly, they may produce excitation.

OPTIMINE TABLETS ARE NOT INTENDED FOR USE IN CHILDREN UNDER 12 YEARS OF AGE.

Use in Pregnancy: Experience with this drug in pregnant women is inadequate to determine whether there exists a potential for harm to the developing fetus.

Use with CNS Depressants: Azatadine maleate has additive effects with alcohol and other CNS depressants (hypnotics, sedatives, tranquilizers, etc.).

Use in Activities Requiring Mental Alertness: Patients should be warned about engaging in activities requiring mental alertness, such as driving a car or operating appliances, machinery, etc.

Use in the Elderly (approximately 60 years or older): Antihistamines are more likely to cause dizziness, sedation, and hypotension in elderly patients.

PRECAUTIONS Azatadine maleate has an atropine-like action and, therefore, should be used with caution in patients with: a history of bronchial asthma, increased intraocular pressure; hyperthyroidism; cardiovascular disease; hypertension.

DRUG INTERACTIONS MAO inhibitors prolong and intensify the anticholinergic (drying) effects of antihistamines.

ADVERSE REACTIONS The most frequent adverse reactions are underlined:

General: Urticaria, drug rash, anaphylactic shock, photosensitivity, excessive perspiration, chills, dryness of mouth, nose, and throat.

Cardiovascular System: Hypotension, headache, palpitations, tachycardia, extrasystoles.

Hematologic System: Hemolytic anemia, thrombocytopenia, agranulocytosis

Nervous System: Sedation, sleepiness, dizziness, disturbed coordination, fatigue, confusion, restlessness, excitation, nervousness, tremor, irritability, insomnia, euphoria, paresthesias, blurred vision, diplopia, vertigo, tinnitus, acute labyrinthitis, hysteria, neuritis, convulsions.

Gastrointestinal System: Epigastric distress, anorexia, nausea, vomiting, diarrhea, constipation.

Genitourinary System: Urinary frequency, difficult urination, urinary retention, early menses

Respiratory System: Thickening of bronchial secretions, tightness of chest and wheezing, nasal stuffiness.

OVERDOSAGE Antihistamine overdosage reactions may vary from central nervous system depression to stimulation. Stimulation is particularly likely in children. Atropine-like signs and symptoms (dry mouth; fixed, dilated pupils; flushing; and gastrointestinal symptoms) may also occur.

If vomiting has not occurred spontaneously, the patient should be induced to vomit. This is best done by having him drink a glass of water or milk after which he should be made to gag. Precautions against aspiration must be taken, especially in infants and children.

If vomiting is unsuccessful, gastric lavage is indicated within three hours after ingestion and even later if large amounts of milk or cream were given beforehand. Isotonic and ½ isotonic saline is the lavage solution of choice.

Saline cathartics, such as milk of magnesia, draw water into the bowel by osmosis and therefore are valuable for their action in rapid dilution of bowel content.

Stimulants should not be used.

Vasopressors may be used to treat hypotension.

FEBRUARY 1977 11055010

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Kenilworth, New Jersey 07033

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Schering



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for relief of allergy symptoms

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V-Cillin K®

penicillin V potassium

is the most widely prescribed brand of oral penicillin



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Oral Solution
125 and 250 mg*/5 ml

V-Cillin K®
penicillin V potassium

Description: V-Cillin K is the potassium salt of penicillin V. This chemically improved form combines acid stability with immediate solubility and rapid absorption.

Indications: For the treatment of mild to moderately severe pneumococcal respiratory tract infections and mild staphylococcal skin and soft-tissue infections that are sensitive to penicillin G. See the package literature for other indications.

Contraindication: Previous hypersensitivity to penicillin.

Warnings: Serious, occasionally fatal, anaphylactoid reactions have been reported. Some patients with penicillin hypersensitivity have had severe reactions to a cephalosporin; inquire about penicillin, cephalosporin, or other allergies before treatment. If an allergic reaction occurs, discontinue the drug and treat with the usual agents (e.g., epinephrine or other pressor amines, antihistamines, or corticosteroids).

Precautions: Use with caution in individuals with histories of significant allergies and/or asthma. Do not rely on oral administration in patients with severe illness, nausea, vomiting, gastric dilatation, cardiospasm, or intestinal hypermotility. Occasional patients will not absorb therapeutic amounts given orally. In streptococcal infections, treat until the organism is eliminated (minimum of ten days). With prolonged use, nonsusceptible organisms, including fungi, may overgrow; treat superinfection appropriately.

Adverse Reactions: Hypersensitivity, including fatal anaphylaxis. Nausea, vomiting, epigastric distress, diarrhea, and black, hairy tongue. Skin eruptions, urticaria, reactions resembling serum sickness (including chills, edema, arthralgia, prostration), laryngeal edema, fever, and eosinophilia. Infrequent hemolytic anemia, leukopenia, thrombocytopenia, neuropathy, and nephropathy, usually with high doses of parenteral penicillin. [102175]

***Equivalent** to penicillin V.

Additional information available to the profession on request.

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Morris E. Chafetz, M.D.,
Founding Director of the National
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is pleased to announce
the opening of a private
residential alcoholism treatment facility
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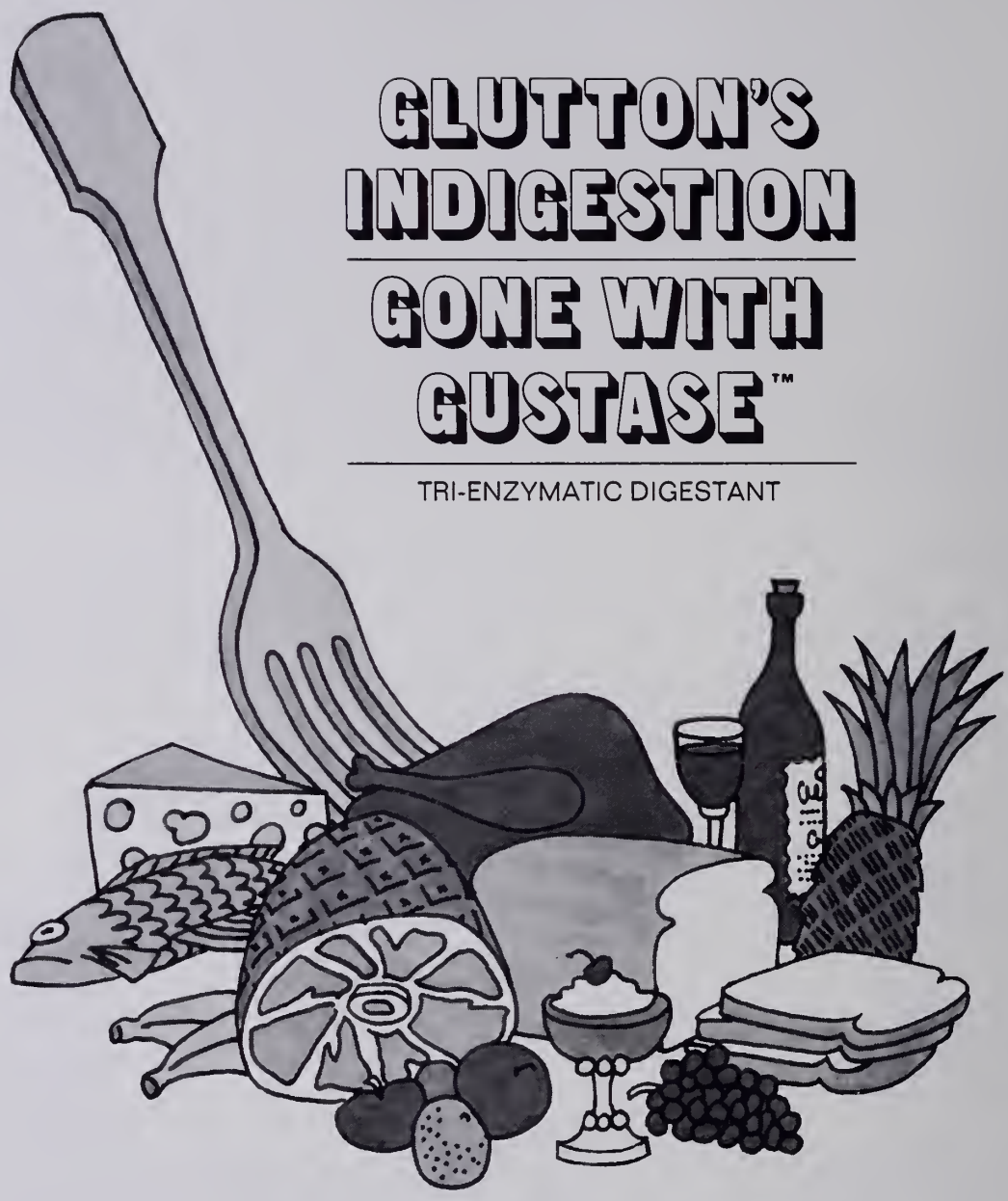


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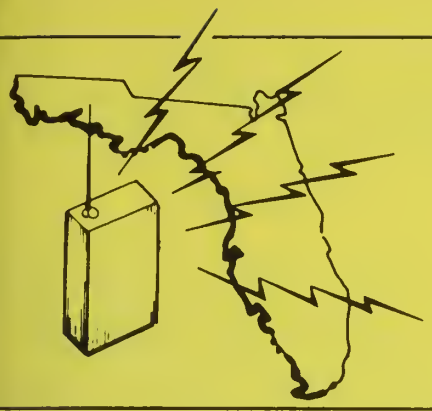


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THE AUXILIARY BEEPER

FLORIDA MEDICAL ASSOCIATION AUXILIARY — CONVENTION--SPRING ISSUE 1980

ANNUAL MEETING PLANS



PEARLS OF GRATITUDE

Thank you for communicating your needs, desires, ideas and concerns. Thank you for educating your Auxiliary and community to the many resources available. Thank you for motivating your Auxiliary to become involved in Child Abuse Prevention, Impaired Physician, Legislation, Political Action, Political Education and a myriad of other programs and projects. Thank you for financial contributions to AMAERF, FMF, IH activities. Thank you for assisting your Society to further the goals of delivering the best medical care to the people of Florida. Thank you for your support, encouragement, kindness and friendship...Thank you for a PEARL year.

YOU ARE INVITED

The DCMA-Auxiliary (Official Hostesses) cordially invite you to attend the FMA Auxiliary 53rd Annual Convention May 7-11 at the Diplomat Hotel, Hollywood Beach. Informative programs, seminars, intriguing speakers and tantilizing luncheons have been planned for your enjoyment. Auxiliary pearls will be on display. Our cultured pearls (past and current presidents) will be honored. Read the agenda, fill out preregistration, hotel reservation forms and purchase luncheon tickets now. We encourage all Auxilians to fly, ride, jog, skate, drive, swim or walk to the Diplomat and pick up some final pearls.

Mrs. Edgar Webb (Doris)
Annual Convention Chairman

WEDNESDAY, MAY 7, 1980

10:00 a.m.-4:30 p.m.	Registration for all State Officers, Chairmen and County Presidents--FMA General Registration, Foyer of the Exhibit Hall.
	Pre-registration for House of Delegates, FMA general Registration, Foyer of the Exhibit Hall.
	Tickets available for AWARDS and FLAMPAC Luncheon, FMA General Registration, Foyer of the Exhibit Hall.
	Hospitality Room--Embassy Room East--Mezzanine.
9:00 a.m.-11:00 a.m.	"Child Abuse Prevention Seminar," Mrs. Arthur L. Trask presiding.
11:15 a.m.-1:15 p.m.	Pre-Convention Executive Committee Meeting and Luncheon Suite of President and President-Elect, Mrs. B. David Epstein presiding.
1:30 p.m.-3:30 p.m.	Pre-Convention Board of Directors Meeting for all STATE OFFICERS, Chairmen and County Presidents. All members are welcome as guests. Mezzanine Theatre.
6:30 p.m.-8:00 p.m.	President's Reception (Cash Bar), Embassy Room East, all FMAA Delegates, State Officers, Chairmen and their guests.

THURSDAY, MAY 8, 1980

7:30 a.m.-8:30 a.m.	Complimentary Continental Breakfast for FMAA Delegates (Badges, please.) Mezzanine Theatre.
8:00 a.m.-4:30 p.m.	Registration at FMA General Registration, Foyer of Exhibit Hall.
	Hospitality Room--Embassy Room East--Mezzanine (Will be closed during AWARDS LUNCHEON, 12:15 p.m. to 1:45 p.m.)
	ART SHOW - Exhibit Hall
8:40 a.m.	PROMPTNESS PRIZE
8:45 a.m.-12:00 Noon	FIRST SESSION HOUSE OF DELEGATES --Mezzanine Theatre. (Badges must be worn by the delegates and they are requested to be seated with their delegation no later than 8:45 a.m.)
	POLISHED PEARLS presented by County Presidents
	Memorial Service - 11:45 a.m. - First Vice-President and President of the Southern Medical Association Auxiliary
12:15 p.m.	DISPLAYING AUXILIARY PEARLS AWARDS LUNCHEON honoring Past-Presidents of the FMAA and presentation of Art Show Awards, Editor's Award, AMAERF, International Health and Membership Awards and Peggy Wilcox Trophy.
1:40 p.m.	PROMPTNESS PRIZE

1:45 p.m.-5:00 p.m.	Second Session House of Delegates–Mezzanine Theatre. (Badges must be worn by the delegates and they are requested to be seated with their delegation no later than 1:45 p.m.)
	POLISHED PEARLS presented by County Presidents.
	Dolores Morgan, M.D., Director of Alcoholism Treatment Program at South Miami Hospital.
	Greetings from AMAA, Mrs. John F. Vaughan, President-Elect 1979-1980.
	Installation of Officers 1980-1981, Mrs. John F. Vaughan
5:30 p.m.-6:30 p.m.	G. Douglas Talbott, M.D., Program Chairman–Disabled Doctors' Plan–Georgia. Joint Session of the FMA and Auxiliary.
	FRIDAY, MAY 9, 1980
7:30 a.m.-8:30 a.m.	Post-Convention FMAA Executive Committee Meeting Suite of President and President-Elect.
8:00 a.m.-3:00 p.m.	Hospitality Room–Embassy Room East–Mezzanine (Will be closed during FLAMPAC LUNCHEON.)
8:00 a.m.-5:00 p.m.	ART SHOW–Exhibit Hall
9:00 a.m.-11:00 a.m.	Post-Convention Board of Directors Meeting--Mezzanine Theatre. Orientation for all 1980-81 State and County Officers, Chairmen, members and guests. Officers and Chairmen are requested to transfer all files for 1980-81 Board. Mrs. Fred P. Swing, 1980-81 President, presiding.
	Officer's Reports
	Chairmen's Reports
	Elect 2 members for state finance Committee
	Check Yearbook
	Upcoming Auxiliary Dates
	AMA A Confluence Information
	Orientation Session : county officers and chairmen with their state counterparts.
	Announcements
12:15 p.m.	POLITICAL PEARLS FLAMPAC LUNCHEON Mr. Kevin Phillips–"An overview of the 1980 Political Scene".

ARE YOU PLAYING?

In line with our president's theme of "Pearls", the Membership Committee has decided to accumulate shells. We are running a "Shell Game" with 20 ways to earn a shell.

Already reports are beginning to drift in from our beachcombers: Polk, Dade, Hillsborough, Duval, Lee and the Panhandle have all sent in information.

Polk had their first male spouse at their Fall luncheon. Dade sent an idea for involving new members by getting them to make ready-cut aprons and bring them to sell at the next meeting. Hillsborough is holding several orientation meetings in different parts of Tampa. Duval honored their "before 1960" members at the November meeting. Lee sends the idea of presenting the committee chairmen to the new members wearing descriptive hats.

There are rumors of increased membership in several counties, but until the figures are in from Jacksonville, we won't report on them. Don't forget our goal of 10% increase - that's over 400 members.

Ruth Coleman, Vice President

AUXILIARY NOMINEES FOR 1980 - 1981

The Nominating Committee presents the following slate of officers to be voted on by the House of Delegates at Convention:

OFFICERS

President
Mrs. Fred P. Swing, (Anne) Collier County (Already elect)
President-elect
Mrs. Frank C. Coleman, (Ruth) Hillsborough County
First Vice-President
Mrs. Michael J. Foley, (Dot) Brevard County
Recording Secretary
Mrs. Milton Tignor, Jr., (Jo) Palm Beach County
Treasurer
Mrs. Daniel B. Nunn (Gloria), Duval County

*DISTRICT VICE*PRESIDENTS*

Northeast
Mrs. Guy T. Selander (Joan) Duval County
Northwest
Mrs. Jack W. MacDonald (Alice) Leon County
West Central
Mrs. Rex Orr (Betty) Pinellas County
East Central
Mrs. Charles Stump (Jo Ann) Volusia County
Southwest
Mrs. Michael J. Murray (Candy) Lee County
South
Mrs. N. Harry Carpenter (Elizabeth) Broward County

Members of the committee were Mrs. James G. White, Chairman (East Central); Mrs. J.T. Cook, Northwest; Mrs. G.T. Selander, Northeast; Mrs. R.L. Dawson, West Central; Mrs. J. Carver, Southwest; Mrs. L.G. White, South.



AMA/A PRESIDENT-ELEC VAUGHAN TO SPEAK

Mrs. John F. Vaughan, President-elect of the Americ Medical Association Auxil will be the installing officer guest speaker at the An Meeting, House of Dele Thursday, May 8 at the Diplo Hotel, Hollywood.

Mrs. Vaughan resides in Vancouver, Washington. has served the national auxiliary as secretary, Wes Regional Vice President, chairman of several committ and on the nominating committee.

Mary Ellen is active in local civic affairs, serving on county's Social Services Administration and Execu Committee and chairs the administration's Drug Committee. She is active in several other commu organizations including the United Way, Kappa Al Theta Alumnae Club and her church.

Before her marriage to John Foley Vaughan, M.D family practitioner in 1945, Mary Ellen was a secon school teacher. Dr. and Mrs. Vaughan are the parent four children and five grandchildren.

Mary Ellen describes her hobbies as skiing, golf gardening, watercolors, and "being a grandmoth

Florida Medical Association Auxiliary, Inc.

FOURTEENTH ANNUAL BENEFIT ART SHOW

Exhibit Rules and Regulations

Read Rules Carefully

1. All entries must be original work.
2. Pictures must be framed and wired for hanging. (Stands will be provided for sculpture, etc.)
3. Each entry must have a typed card indicating Name, Address, Medium, Dimensions and Title. Please list price if entry is for sale; otherwise, mark not for sale (NFS).
4. Only one artist's name should be listed for each registration slip.
5. A registration fee of $10 will be charged for each entry. Entry fees are tax deductible.
6. All registration slips and checks must be sent in together no later than April 23, 1980.
7. All pre-registered entries are to be delivered by hand to the Exhibit Hall at the Diplomat Hotel no later than 3:00 p.m. Wednesday, May 7. Shipped entries will be refused.
8. All entries must remain on exhibition until noon Saturday, May 10. They MUST be picked up between noon and 1:00 p.m., Saturday.
9. We will not be responsible for entries not picked up by 1:00 p.m., Saturday, May 10, 1980.
10. Doctors, their wives and children are eligible to enter. Entry fees will be donations to AMA-ERF, divided equally among Florida medical schools.

Kindly enter my registration to show in the Benefit Art Show.

Fee of $ _____ for _____ entries is enclosed. I agree to abide by the rules and regulations for exhibiting material in the show.

Name _____

Address _____

City _____ County _____

I will be showing in the following categories: Please check (X) appropriate category (categories) applying to your entry (entries).

( ) A. Painting. Include any media in color: acrylic, oil, casein, collage, watercolor, pastel, etc.

Size: _____ (H) x _____ (W) To be hung on wall.

( ) B. Graphics. Include a pen and ink, charcoal, photography, etc.

Size: _____ (H) x _____ (W)

( ) C. Crafts. Include sculpture, pottery, ceramics, mosaic, weaving, jewelry, etc.

Size: _____ (L) x _____ (D) x _____ (H)

( ) I am the son/daughter of a Florida physician. Age _____

Judges will give "Awards of Merit" and "Best in Show." An "Editor's Award," given by the Journal of the Florida Medical Association, will be used on the cover of a future issue of the FMA Journal.

A registration fee of $10 will be charged for each entry. Make checks payable to:

FMA-A Art Show
c/o Mrs. Carlos G. Llanes
11225 S.W. 58th Court
Miami, Florida 33156

NOTE: It is most important to know the size of your art objects, paintings, etc., to enable us to display them more professionally. We will not be responsible for damage or loss of any entry.

REGISTRATION DEADLINE APRIL 23, 1980.

Judging will take place beginning at 9:00 a.m. on Thursday, May 8, 1980.

LOOK AT THE SYMPTOMS

"I remember Mike as an outgoing, white-haired, apple-cheeked man with a boyish grin. Although we were not close friends, our paths crossed frequently, and I always felt comfortable with him. Well-trained in medicine, he kept up with current developments, served willingly and well on many hospital committees, held offices in our Academy of Medicine, and was often involved in community health activities. He had a large following of devoted patients whom he served in the best traditions of family practice.

Mike was born and raised in our community, and he had a host of friends, but his social life was quiet. He was a devout Catholic and a family man who enjoyed attending church affairs with his wife and their several children. He was very well thought of by one and all.

Mike died when he was about 50 years old and was buried with a quiet ceremony. There was no public announcement of the cause of death. Some time later, however, we were shocked to learn that he was an alcoholic and had died of barbiturate overdose, possibly suicidal. Only then did bits and pieces of information from the last year or two begin to have meaning. I had seen very little of Mike for several months before he died. On a few brief encounters, he had seemed tired and less ebullient than usual and had fussed uncharacteristically about the stresses of his practice. He had failed to show up for several meetings and had declined a couple of committee assignments.

There had been rumors that one of his sons was having adjustment problems, and his favorite daughter was entering a convent. His previously slender, vivacious wife had gained a lot of weight and appeared anxious and depressed. Some of his old patients complained of difficulty reaching him and of his curt behavior. Much later, a nurse told of an unintelligible, nocturnal conversation with him when she called to verify an order. In retrospect, it was clear that Mike had been in serious trouble for many months. We learned that he had neither sought nor been offered assistance by his colleagues---we were very sad.

Now, I don't know why Mike was an alcoholic, but I do know that he was not a "bad" man. He was a sick man, and his sickness had profound effects upon those nearest and dearest to him and carried potential danger to his patients. Compounding the tragedy is the sad fact that neither he nor we could recognize the clues of his illness that are so clear in retrospect. Had it been otherwise, this fine man might have been offered treatment."

The above story is not fiction. It is a composite of facts compiled by Perry R. Ayres, M.D., Clinical Professor of Preventitive Medicine, Ohio State University and printed in an article by him in Vol. 73, No. 11, November, 1977 of the Ohio State Medical Journal. Alcohol and drug addiction, left unchecked, is a relentlessly progressive disease. It cuts to the heart of a personality and all the relationships surrounding it. Ignoring the inevitable end of this progression, we fear disgrace or financial disaster, do nothing and hope "things will work themselves out". Read Mike's story again.

Dear Readers;

This issue is a combined issue of the Convention and Spring Issues and will appear in the April issue of the FMA Journal. Please note all important forms regarding Day in Legislature, Convention and Art Show. Respond promptly. There will be NO further mailings of these forms. This is THE Call to Convention.

My thanks and very best wishes to Dr. Gerold Schiebler, Editor of the Florida Medical Association Journal and to Mrs. Louise Rader, Managing Editor of the Journal. Dr. Schiebler and Mrs. Rader will retire with the May Issue, 1980.

I wish to thank all of the contributors to **THE BEEPER**, for their cooperation and support the past two years. It has been a very rewarding experience for me to have served as your Editor. My very best wishes for much success to your new Editor, Lita Martija. Please send editorial materials for the Fall Issue by June 1 to her at 1231 Arden St., Longwood, Fla. 32750.

Jo Tignor

MRS. YOW TO VISIT

Mrs. Raymond Yow from Salisbury, Md. President o Southern Medical Association Auxiliary will be our gues and conduct the Memorial Service.

DR. MORGAN TO BE KEYNOTE CONVENTION SPEAKER



Dolores Morgan, M.D. ha been director of the Alcoho ism Treatment Program at Sout Miami Hospital since 197 She will address the House Delegates on Thursday, May 1980 during the annual meetir at the Diplomat Hotel, Holl wood.

Dr. Morgan was a nurse for 23 years before enterir medical school and served two years active duty in t Navy during the Korean War. She is a graduate of Indiar University Medical School and interned at Henry Fo Hospital in Detroit. She served one year residencies family practice at Harvard and the University of Miar

XCITING DAY IN LEGISLATURE PLANNED

he Tallahassee Hilton will set the stage for the 1980 D/ In The Legislature, Wednesday, April 16th at 9 a.m. al Thursday, April 17th at 9 a.m. Fifty rooms have been re erved with the reservation deadline being March 22nd. R m rates are $25, single; $31 double. Contact the hotel d ctly for reservations.

s a new feature this year everyone is urged to invite h r legislators to the cocktail/buffet at the home of Dr. a Mrs. Michael Mouton, 2800 Cline ($10 per person).

peakers will include Dr. Richard Hodes, Mallory H ne and FMA Staff. Sufficient time will be allowed to m nitor committees or observe the House and/or Senate n ession.

RESERVATION FORM FOR
DAY IN THE LEGISLATURE

Name _____

Address _____
street city county zip

Please make reservations for:

Luncheon April 16 _____ number
$5 per person

Cocktails/Buffet April 16 _____ number
$10 per person

I have enclosed check(s) in the amount of _____

RETURN BY MARCH 22nd to Beebe White, 344 John Anderson Dr., Ormond Beach, FL 32074

REGISTRATION, ANNUAL CONVENTION FLORIDA MEDICAL ASSOCIATION AUXILIARY

Name _____ Title _____

Address _____

County _____ City _____ Zip _____

I will _____ will not _____ attend Executive Committee Meeting, Wednesday May 7 at 11:15 a.m. President's suite Diplomat Hotel, Hollywood.

I will _____ will not _____ attend Pre convention Board of Directors Meeting, Wednesday May 7 at 1:30 p.m. Diplomat Hotel, Hollywood.

I will _____ will not _____ attend House of Delegates Meeting, Thursday, May 8 at 8:45 a.m. Diplomat Hotel, Hollywood.

I am _____ am not _____ a Delegate. All Delegates, members and guests welcome.

LUNCHEONS

Thursday, May 8 - AWARDS LUNCHEON "DISPLAYING AUXILIARY PEARLS".
cost - $15.00 I will need _____ ticket(s).

Friday, May 9 - FLAMPAC LUNCHEON "POLITICAL PEARLS".
cost - $15.00 I will need _____ ticket(s).

Please complete and make checks payable to FMA A Convention NOW. Mail to Mrs. G. Gage, Registration Chairman
1022 Manati
Coral Gables, Fla. 33146

Please make Hotel reservations directly with the Diplomat Hotel, 3315 South Ocean Drive, Hollywood Beach, Fla. 33022.

A WARM WELCOME
FLORIDA MEDICAL ASSOCIATION, INC.
MAY 7—11, 1980
Diplomat Resort and Country Clubs

Arrival Date _____ Departure Date _____

Names of Occupants, please print _____

_____

_____

_____

Total No. of Rooms _____ Guests _____

Address _____

Affiliation _____

Street Address _____

City _____ State _____ Zip _____

Remarks _____

(PLEASE CHECK RATE DESIRED)

Daily Rates

Please Reserve	TOWER & EAST BLDG. Convention Center Valet/Garage Parking	WEST BLDG. & Golf & Racquet Club Casual Atmosphere Complimentary Self Parking
European Plan (No meals)		
Double Room (2 persons)	$40 ( )	$38 ( ) $34 ( ) $34 ( )
Single Room (1 person)	$40 ( )	$38 ( ) $34 ( ) $34 ( )
Third person in Double Room	$10 ( )	$10 ( ) $10 ( ) $10 ( )

PARLOR RATES — Executive $50 ( ), Deluxe $40 ( )

Occupancy cannot be assured before 3 p.m. of the date of reservation & your rooms will be held until 6 p.m. Unless otherwise specified all reservations are made subject to failure of guests to vacate or conditions or causes beyond our control. Checkout time 1 p.m.

ELECTION YEAR!!! PAC DUES DUE!!!

anuary 1 began a new FLAMPAC/AMPAC year. 1980 C dues are now due. Memberships are: Sustaining 1); Regular $40 doctors and $20 spouses. Please make k payable to FLAMPAC and also mark it auxiliary so credit will be given us through our FLAMPAC irman, Connie Moore. Mail check to FLAMPAC, P.O. 2371, Jacksonville, Fla. 32203. Payment of Voluntary MPAC/AMPAC dues supports political activity and erefore not tax deductible.

opy of our report is filed with the FEC and is available for ase from FEC, Washington, D.C.)

LOGIES TO: MRS. JEAN ROYER, Orange County delegate to AMA/A Confluence in October. We regret her name was omitted.

EUROPEAN ADVENTURE

A two-week luxury holiday via Pan Am Chartered Jet to Paris, Switzerland and Florence will depart Tampa June 30, returning July 13, 1980. The cost per person will be $2198. For further information contact Ruth Henderson 904-629-1211.

1979-1980
OUR ILLUSTRIOUS PEARL
CONNIE MOORE
APPOINTED TO AMPAC BOARD





DADE COUNTY SHAPES UP

The Dade County Medical Association Auxiliary introduced ''Shape Up For Life'' to the Miami, Florida area via a Health Fair which was held at the Dadeland Shopping Mall. The Health Fair is sponsored each year by South Miami Hospital, and this is the second year that the auxiliary has participated.

A puppet show entitled, ''Shape Up For Life'' featured the Interplast South Puppets, Louie, Wart, Floribunda, and Take Me to Your Leader, and delighted youngsters passing by.

Children of auxiliary members took the parts of the puppets, and each puppet show was unique in its presentation and interpretation. The actors, ranging in ages nine to thirteen, had as much fun performing as the audience did watching.

Yoga demonstrations were presented by an auxiliary member, Casey Lustgarten, and Parvati, a local yoga teacher. Both encouraged passersby to participate in yoga exercises.

''Shape Up For Life'' buttons and pamphlets were also distributed. Scripts for the puppet show, which was conceived and written by Edie Epstein, Florida Medical Association Auxiliary President, and Janis Ramirez, Dade County Medical Association Auxiliary President, are available for use in local schools.

CALENDAR OF COMING EVENTS

April 9-11	CHILD ABUSE SEMINAR sponsored by the Florida Center for Children and Youth. To be held in Tallahassee. Contact Rhee Sailors, 102 S. Calhoun St., Tallahassee, Fla. 32301.
April 16-17	DAY IN THE LEGISLATURE, TALLAHASSEE HILTON
May 7-9	FLORIDA MEDICAL ASSOCIATION AUXILIARY CONVENTION, Diplomat Hotel, Hollywood, Fla.
July 20-23	AMERICAN MEDICAL ASSOCIATION AUXILIARY CONVENTION, Drake Hotel, Chicago, Ill.
September 8-10	FMA/A FALL CONFERENCE, Hyatt House Hotel, Sarasota, Fla.



PHILLIPS TO SPEAK AT FLAMPAC LUNCHEON

Kevin P. Phillips will be keynote speaker for the FL PAC luncheon, Friday Ma at the Diplomat Hotel, H wood.

Mr. Phillips holds degrees from Colgate Univers University of Edinburgh and Harvard Law School. has held various positions involving the political scene has been president of American Political Research C oration since 1971. He is also a noted columist and aut

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Professional Liability Legal Update

Medical Mediation Act Unconstitutional

On Thursday, February 28, 1980, the Supreme Court of Florida held the Florida Medical Mediation Act unconstitutional. The issue presented to the Supreme Court was whether the time limitations established by the Medical Mediation Act may be extended or stayed in any way, and if not, whether strict application of these statutory time periods is constitutional. The time limitations in question provide that a final mediation hearing must be commenced within six months of filing a claim and must be completed no later than ten months after the claim is filed. If these time limitations are not met, jurisdiction of the mediation panel is lost and mediation is terminated.

At the outset, the Supreme Court noted that the lower appellate courts have been correct in holding that medical mediation jurisdiction terminates in all cases in which the final hearing is not concluded within ten months. The time limitations of the Act were found to be unalterable for two reasons: (1) if the Legislature had intended otherwise it could have easily included a provision for time extensions in the Medical Mediation Act and (2) the provisions of the Florida Constitution guaranteeing an individual's right to speedy access to the courts dictates a stringent enforcement of the time periods.

In response to the argument that the constitutional infirmities of the Act could be cured by allowing judicial referees to grant extensions of time, stays, etc., the Court responded that if it were possible to interpret the Act to allow time extensions it would not hesitate to do so, however, no such saving construction of the Medical Mediation Act was deemed possible. If the extensions were permitted, what was originally contemplated as an inexpensive, summary procedure would be extended to twelve, fourteen, or possibly even sixteen months or more, thereby effectively denying a claimant access to the courts.

Although the Court felt that the ten month time limitation was not subject to extension it, likewise, felt that in the cases before it, application of the ten month time limitation served to deprive petitioner/physicians of their right to due process of law. The Court considered Petitioners to be victims of "insidious defects" which occasionally intrude upon the judicial system — prejudice and unavoidable delay caused by a congested court docket. Normally these defects are easily remedied by the declaration of a mistrial or the grant of a continuance. But the Medical Mediation Act with its inflexible time limitations afforded the petitioners no possible remedy. The Act arbitrarily deprived petitioners of the opportunity to correct fundamental unfairness in the mediation process solely because that unfairness appeared at a late stage in the proceedings. "It simply offends due process to countenance a law which confers a valuable legal right, but then permits that right to be capriciously swept away on the wings of luck and happenstance," the Court stated.

The Supreme Court did not limit its findings of unconstitutionality to the cases before it. Although it had originally upheld the facial validity of the Medical Mediation Act in *Carter v. Sparkman*, after a "painstaking examination" of over seventy cases the Court reached the conclusion that the inflexible time limitations had proven intrinsically unfair and arbitrary in their application and, thus, declared the entire Act unconstitutional.

The Court's finding of unconstitutionality will have prospective application only. In any case where the written decision of the medical mediation panel has been filed with the clerk of the court on or before February 28, 1980, a party may introduce that decision in evidence. In all other cases, medical mediation proceedings are terminated and declared void as of February 28, 1980. A party shall have sixty days from February 28, 1980 in which to file a complaint for medical malpractice in circuit court if the portion of the applicable statute of limitations not tolled is less than sixty days. If the portion of the applicable statute of limitations remaining after termination of medical mediation jurisdiction is more than sixty days, the action may be filed any time before the statute of limitations expires.

The Court's decision was by a 6-1 vote with Justice Alderman filing a concurring and dissenting opinion in which he agreed that the ten month time limit was jurisdictional, but voted not to strike down the Act in its entirity. Justice Alderman felt that, balanced against the few cases where the mechanism of medical mediation has broken down, there probably have been thousands of mediation cases throughout the state where mediation has worked and that overall, mediation has had the beneficial effects of eliminating frivilous claims and encouraging settlements of meritorious claims.

Prepared and submitted by John E. Thrasher, J.D., Vice President and Legal Counsel and Anthony J. McNicholas, III, J.D., Associate Legal Counsel, Professional Insurance Management Co. (PIMCO), Jacksonville, Florida.



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A child between the ages of six months and six years, for example, can get at least three-fourths of his daily dietary allowance for calcium, riboflavin, vitamins D and B_{12}, phosphorous, and protein from just three glasses of milk. And milk is also a good source of vitamins A and B_6, as well as thiamin and niacin.

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Two to three 8 oz. glasses per day.

Children 6 to 12 years
Three or more 8 oz. glasses per day.

For a free copy of the Dairy Council Digest issue titled, "Composition and Nutrient Value of Dairy Foods," contact your local Dairy Council or write the National Dairy Council, 6300 North River Road, Rosemont, Illinois 60018.

Per cent of Recommended Daily Allowance contributed by three 8 oz. glasses of fortified milk.

	6 mos.—1 yr.	1 yr.—3 yrs.	3 yrs.—6 yrs.
Calcium	100%	100%	100%
Riboflavin	100	100	100
Vitamin B_{12}	100	100	100
Protein	100	100	80
Phosphorus	100	85	85
Vitamin B_6	76	51	34
Vitamin D	75	75	75
Niacin*	71	63	47
Thiamin	56	40	31
Vitamin A	46	46	37

*maximum niacin equivalents based on: 60 mg tryptophan=1 mg niacin

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Dosage and Administration: Average initial dose is 100 mg to 300 mg q12h depending on the age and weight of the patient and the severity of the disease. See package insert for full prescribing information.

See following page for a brief summary of prescribing information.

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Description: THEO-DUR Sustained Action Tablets contain anhydrous theophylline, with no color additives.

Actions: The pharmacologic actions of theophylline are as a bronchodilator, pulmonary vasodilator and smooth muscle relaxant since the drug directly relaxes the smooth muscle of the bronchial airways and pulmonary blood vessels. Theophylline also possesses other actions typical of the xanthine derivatives: coronary vasodilator, diuretic, cardiac stimulant, cerebral stimulant and skeletal muscle stimulant. The actions of theophylline may be mediated through inhibition of phosphodiesterase and a resultant increase in intracellular cyclic AMP which could mediate smooth muscle relaxation.

Indications: Symptomatic relief and/or prevention of asthma and reversible bronchospasm associated with chronic bronchitis and emphysema.

Contraindications: THEO-DUR is contraindicated in individuals who have shown hypersensitivity to any of its components or xanthine derivatives.

Warnings: Excessive theophylline doses may be associated with toxicity; serum theophylline levels should be monitored to assure maximum benefit with minimum risk. Incidence of toxicity increases at serum levels greater than 20 mcg/ml. High blood levels of theophylline resulting from conventional doses are correlated with clinical manifestations of toxicity in: patients with lowered body plasma clearances, patients with liver dysfunction or chronic obstructive lung disease, and patients who are older than 55 years of age, particularly males. There are often no early signs of less serious theophylline toxicity such as nausea and restlessness, which may appear in up to 50% of patients prior to onset of convulsions. Ventricular arrhythmias or seizures may be the first signs of toxicity.

Many patients who have higher theophylline serum levels exhibit a tachycardia. Theophylline products may worsen pre-existing arrhythmias.

Usage in Pregnancy: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development, but neither have adverse effects on fetal development been established. This is, unfortunately, true for most anti-asthmatic medications. Therefore, use of theophylline in pregnant women should be balanced against the risk of uncontrolled asthma.

Precautions: THEO-DUR TABLETS SHOULD NOT BE CHEWED OR CRUSHED. Theophyllines should not be administered concurrently with other xanthine medications. It should be used with caution in patients with severe cardiac disease, severe hypoxemia, hypertension, hyperthyroidism, acute myocardial injury, cor pulmonale, congestive heart failure, liver disease and in the elderly, particularly males, and in neonates. Great caution should be used in giving theophylline to patients in congestive heart failure since these patients show markedly prolonged theophylline blood level curves. Use theophylline cautiously in patients with history of peptic ulcer. Theophylline may occasionally act as a local irritant to G.I. tract although gastrointestinal symptoms are more commonly central and associated with high serum concentrations above 20 mcg/ml.

Adverse Reactions: The most consistent adverse reactions are usually due to overdose and are:

Gastrointestinal: Nausea, vomiting, epigastric pain, hematemesis, diarrhea.

Central Nervous System: Headaches, irritability, restlessness, insomnia, reflex hyperexcitability, muscle twitching, clonic and tonic generalized convulsions.

Cardiovascular: Palpitation, tachycardia, extrasystoles, flushing, hypotension, circulatory failure, life threatening ventricular arrhythmias.

Respiratory: Tachypnea.

Renal: Albuminuria, increased excretion of renal tubular cells and red blood cells; potentiation of diuresis.

Others: Hyperglycemia and inappropriate ADH syndrome.

How Supplied: THEO-DUR 100 mg, 200 mg and 300 mg Sustained Action Tablets are available in bottles of 100, 1000, and 5000, and in unit dose packages of 100 (20 x 5's).

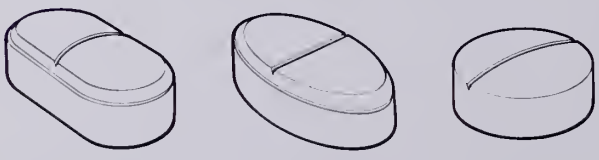
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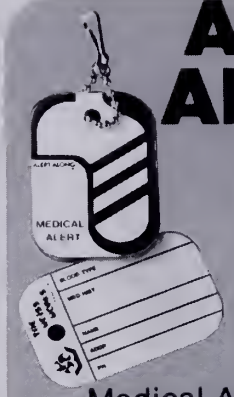
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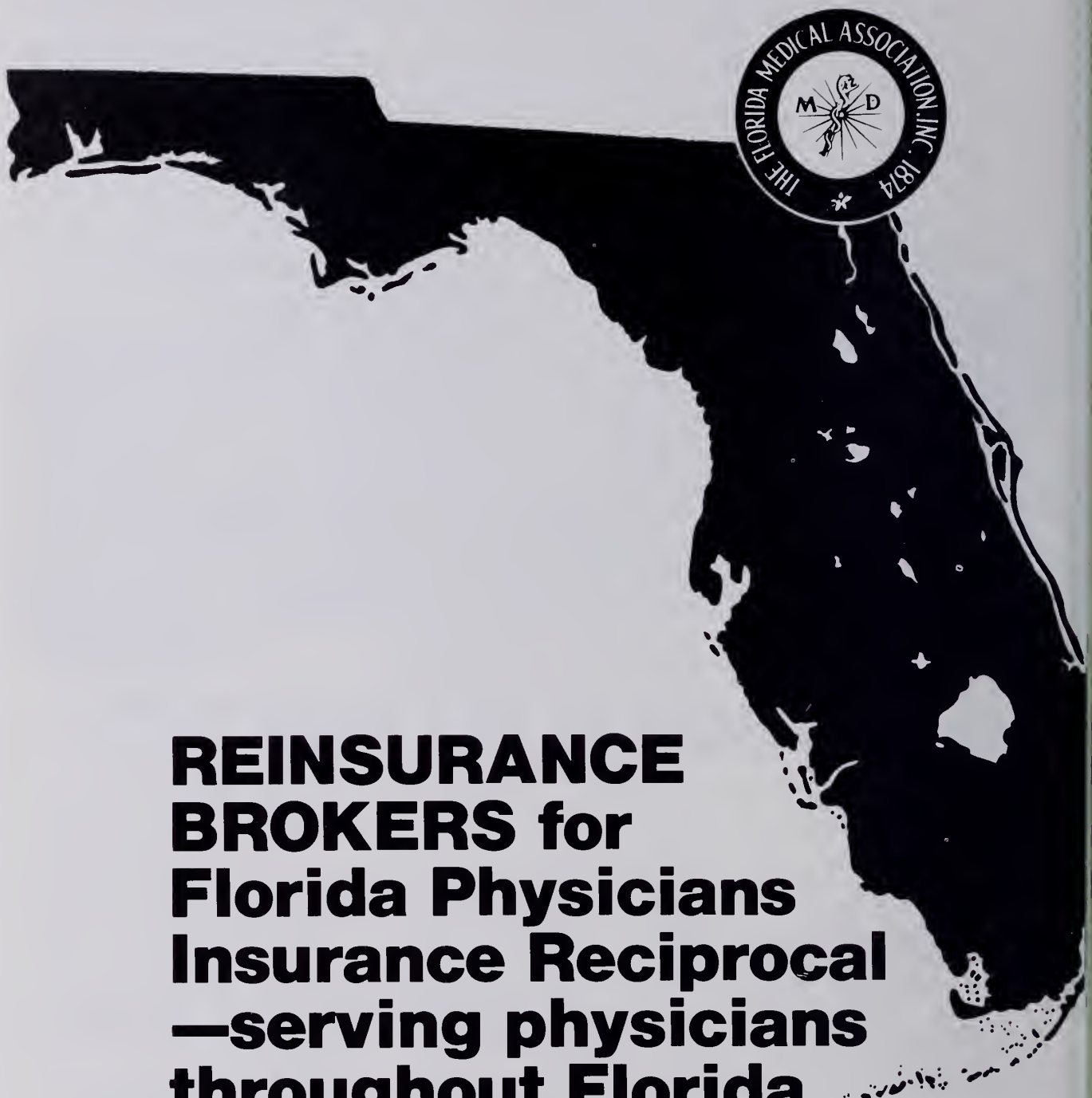
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Summary of the FMA Board of Governors Meeting March 15, 1980

The following is a summary of the actions taken by the Board of Governors at its meeting on March 15, 1980.

THE BOARD:

Recovery of Costs

Directed that the Association establish as its highest priority during the 1980 Legislative Session the enactment of legislation to provide for recovery of costs in civil proceedings and that every reasonable asset be utilized to bring about passage of this legislation.

The bill, which will be sponsored by the FMA, provides that in all civil proceedings that attorney's fees will be paid to the prevailing party except in cases when the party is insolvent or poverty stricken. In addition, before initiating a suit in behalf of a client, every attorney must inform his client in writing as to the provision of this bill. Passage of this legislation is vital in the face of an imminent malpractice crisis physicians are once again facing in Florida as a result of the Florida Supreme Court's action on February 28, 1980, in declaring the medical mediation panel statute as unconstitutional. The Court's ruling closed the door on any remedial legislation to resurrect the mediation statute thus making passage of recovery of costs bill imperative to maintain stability in the medical professional liability market.

Special Committee on Finance

Directed that the report and recommendations of the Special Committee of the Board on Finance be approved and transmitted to the House of Delegates.

This Committee was authorized by the Board of Governors and appointed by the President to conduct an in-depth review and evaluation of the Association's current financial condition as well as future projections. The Committee's report and recommendation is included in the Delegates' Handbook.

FMA Awards

A. H. Robins Award

Selected the recipient for the 1980 A. H. Robins Award for community service by a physician to be presented at the House of Delegates in May of 1980.

Certificate of Appreciation

Selected a physician to be nominated to the House of Delegates as recipient of the 1980 Certificate of Appreciation.

Distinguished Layman's Award

Selected the recipient for the 1980 Distinguished Layman's Award to be presented at the House of Delegates in May of 1980.

FMA Annual Meeting

Blue Shield Informational Meeting

Approved a Blue Shield informational meeting to be held in conjunction with the Annual Meeting on Thursday, May 8th, at 8:00 a.m. The purpose of the meeting will be to inform the FMA membership of the current activities of Blue Shield including its proposed future structure.

Health Run

Approved FMA sponsorship of a health run during the Annual Meeting for physicians, their families and guests. Detailed information will be included in the special Annual Meeting flyer being mailed to the membership.

Good Housekeeping's Family Physician of the Year

Enthusiastically expressed support for the nomination of Joseph C. Von Thron, M.D., Cocoa Beach, by the Florida Academy of Family Physicians as recipient of the 1980 Good Housekeeping's Family Physician of the Year Award.

National Health Service Corps

Authorized the Florida Medical Foundation to give consideration to the feasibility of contracting with the United States Public Health Service for administration of the National Health Service Corps in Florida.

During the past year, some 2,200 medical students were obligated to the PHS and there has been little sensitivity to the areas in which they are placed and little consultation with local county medical societies. It is hoped that more active involvement in this program will influence the distribution of PHS physicians to areas where they are most needed and thus avoid future indiscriminate placement.

Committee on Membership and Discipline

Nominated physicians to the House of Delegates for election to the Committee on Membership and Discipline for terms expiring in 1980.

FMA Councils and Committees

Impaired Physicians Program

Pursuant to the actions of the House of Delegates in May 1979, a Committee was established to study and make recommendations regarding the establishment of a statewide impaired physicians program.

The Board, pending the identification of the availability of funds by the Executive Committee, approved in principle and referred to the House of Delegates an extensive report and recommendations for the establishment, financing, and implementation of a statewide impaired physicians program for physicians whose use of alcohol or other chemical substances interferes with their ability to practice medicine.

Peer Medical Utilization Review

Alcoholic Rehabilitation Program

Expressed objection to the Department of HRS' regulation regarding the 21 day limitation in coverage by Medicare for alcoholic rehabilitation. At the present time, Medicare allows for only 21 days coverage for alcoholic rehabilitation whereas most programs are currently designed for 28 day duration.

PMUR Operating Procedures

Approved amended operating procedures for the PMUR program which include modifications to resolve concerns expressed by a number of county medical societies regarding inequities in the procedures. The Board also approved the development of a reporting mechanism to enable county medical societies to identify and report physicians whose quality of care is suspect and who are currently not being identified through the PMUR process.

Workshop

Authorized a workshop on PMUR for county medical societies during the FMA Annual Meeting on Friday, May 9th, at 8:30 a.m. The purpose of the workshop is to discuss in detail the referral and review process. County medical societies are urged to take advantage of this opportunity to learn more about the peer review program.

Council on Legislation

In addition to establishing recovery of costs as the number on legislative priority, the Board approved the following positions on a number of issues effecting health to be addressed during the Session.

Expressed "SUPPORT" for:

- Protection of physician's own medical treatment records from acquisition by investigators from the State Board of Medical Examiners.
- Legislation which would reinstate the provisions that no more than two physician assistants may be supervised by any individual medical doctor and that would eliminate the ability of unlicensed medical doctors to be certified as physician assistants.
- Confidentiality of medical records.
- Reinstatement of legislation which requires preschool physicals.
- Legislation to abolish lay midwives.

Expressed "OPPOSITION" to:

- HB 349 — Triplicate prescriptions, because of the provisions which give the Florida Department of Law Enforcement overall responsibility for acquisition and maintenance of records and the fact that patient names are released to state agencies, thus violating confidentiality provisions; and further, the position of the FMA be made clear to endorse all practical means that might be taken to correct the drug abuse problem in Florida.
- State assumption of responsibility of county health unit functions.
- Creation of state health data bank.
- SB 228 — Prohibition of referral by physicians to facilities in which they have an ownership interest.
- Certificate of Need for physicians' office equipment.
- Prescription of drugs by physician assistants.
- Prescription and administration of drugs by optometrists.(other than use for diagnostic purposes).
- Reporting system for physicians who have ownership in health care facilities or drug companies.(truth in sickness).
- SB 283 — Mandated use by all hospital medical staffs of problem-oriented medical records.
- HB 272 — Allows hospitals to be designated as medical director for advanced life support system and removes from the medical director the responsibility for the actions of paramedics.
- HB 273 — Elimination of requirement for medical directors for advanced life support systems.
- Legislation to require certification for physicians who use acupuncture.

"ENDORSE" legislation:

- Requiring payment on an out-patient basis for surgical and diagnostic services that would be covered on a hospital in-patient basis.(SB 59) providing such an act would not prohibit insurance companies from expanding out-patient coverage to include psychiatric services.

- HB 526 — Requirement for all health insurers to offer catastrophic health insurance plans.
- SB 95 — Exemption for liability for persons who administer required immunizations to school children.
- SB 176 — Prohibits insurance companies from denying claims solely because a facility lacks surgical facilities or because it is primarily of a rehabilitative nature.
- SB 193 — Immunity from liability for volunteer physicians providing emergency care to injured athletes.
- SB 213 — Expands the time for review of various practice acts under the Florida Sunset Act and creates a permanent legislative committee to provide overview for regulatory agencies.
- HB 33 — Repeal of mandatory cervix and breast exams in non-public hospitals.
- HB 37 — Licensure of acupuncture clinics.
- HB 168 — Exemptions from liability for voluntary team physicians for elementary or secondary school athletes.
- HB 237 — Places in the statute the requirement for a five member advisory council to the children's medical services office.
- HM 307 — Establishes a special joint legislative committee to study federal regionalism.
- HM 387 — Constitutional amendment with regard to right of privacy.

Council on Medical Services

Voluntary Health Agencies Recognition Program

Approved modification of the voluntary health agency recognition program to provide that a formal review of recognized voluntary health agencies be conducted every three years rather than the current annual review.

Supervision of Advanced Nurse Practitioners

Recommended to the State Board of Medical Examiners and Board of Nursing Representatives to the Advanced Registered Nurse Practitioner Joint Advisory Committee that a rule be developed which would require that ANPs be under the direct supervision of a specific physician within the same community that an ANP practices; and further, should the Advisory Committee or Board of Nursing not accept this recommendation, that the FMA seek a legislative revision that would implement the intent of the recommendation.

Prison Drug Abuse Programs

Recommended to the Department of Corrections appointment of a study commission on prison drug abuse treatment programs and that the commission be charged with the responsibility for analyzing the costs of these programs as compared to their effectiveness or success ratio.

Juvenile Shelters

Requested the Department of HRS to establish a task force to study and make recommendations on health care services for dependent and delinquent children in state facilities.

Pre-School

Endorsed the proposed pre-school physical examination form developed by the Committee on School Health in cooperation with the Florida Pediatric Society.

Drug Prescribing

Reiterated the position of opposing any drug prescribing role by any group other than physicians under the appropriate Five Chapters of the Florida Statutes.

Council on Scientific Activities

CME Requirements

Reaffirmed existing policy that the requirements of the FMA CME program be applied equally to all practicing members who are not individually exempted for unique reasons.

Council on Specialty Medicine

Infant Screening Program

Recommended that Department of HRS amend the rules and regulations for Florida's Infant Screening Act as follows:

1. To eliminate the requirement that a participating laboratory must perform screening tests of a minimum of 50,000 newborns annually and only require that any participating laboratory demonstrate quality control, proficiency, and willingness. In addition, all participating laboratories should be required to conform to present and future national standards in performing such tests.
2. To formulate a mechanism of prompt reporting to identify responsible physicians at institutions in a minimum turn-around time.
3. That the Infant Screening Act be revised to include on the advisory council a broad range of specialty groups including but not limited to private practitioners in pediatrics, pathology, obstetrics, and family medicine.

Council on Government Programs

HRS — Psychiatric Services

Supported continuation of the investigation into contracting for psychiatric services at state hospitals with regard to quality medical care in consultation with the Council of District Branches of the American Psychiatric Association.

Statewide Health Coordinating Council

Recommended to the Statewide Health Coordinating Council, State Health Planning and Development Agency and Health Systems Agencies that all reports and position papers be properly documented including the name of the author(s).

FMA Journal

Approved nominations for appointment or reappointment to the Editorial Board of the FMA Journal and Committee on Scientific Publications for the year 1980-1981.

Associate Editors

Clyde M. Collins, M.D., Jacksonville
E. Charlton Prather, M.D., Tallahassee

Assistant Editors

Edward Pedrero, M.D., Tampa
James K. Conn, M.D., Tallahassee
Lee A. Fischer, M.D., West Palm Beach

Historical Editor

William M. Straight, M.D., Miami

Book Review Editor

F. Norman Vickers, M.D., Pensacola

FMA Auxiliary

The Board expressed appreciation to the FMA Auxiliary for its many exemplary activities conducted in behalf of organized medicine and the public, particularly in the areas of legislative and FLAMPAC activities and the active interest shown in the impaired physicians program. Special commendation was paid to the Auxiliary for the Child Abuse Program which included dissemination of a brochure on child abuse throughout the Florida school system.

Annual Reports and Resolutions

The Board reviewed and submitted to the House of Delegates for consideration the Annual Report of FMA Councils and Committees and resolutions submitted by County Medical Societies.

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Diabetes mellitus	Gouty arthritis
Bronchial asthma	Sulfonamide hypersensitivity

Like any antihypertensive, use with caution in severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

work/play—normal hemodynamic responses to exercise maintained.

love—low incidence of impotence and/or loss of libido: 2.8% in 1,923 patients studied.[1]

cardiac output—tends to return to control values during long-term therapy.

blood flow—preserved in kidney.

No Single Advantage Determines Drug Choice.

Other factors must include:

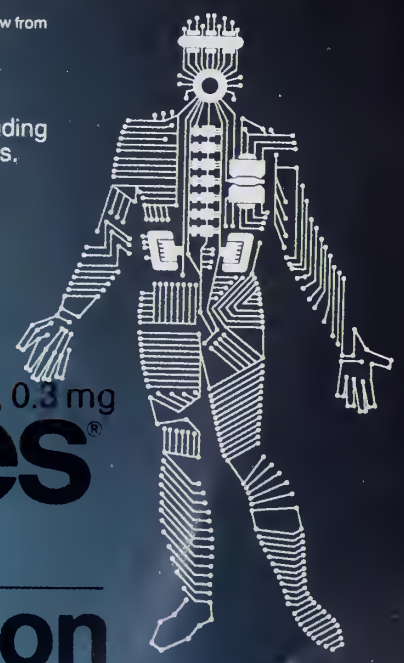
The drug's effectiveness in a given patient, its side effects, warnings, precautions, tolerance, etc. A rational therapeutic choice depends on a careful assessment of all such factors.

*Central alpha-adrenergic stimulation decreases sympathetic outflow from the brain, as shown in animal studies.

1. Data on file at Boehringer Ingelheim Ltd.

Please see last page for brief summary, including warnings, precautions, and adverse reactions.

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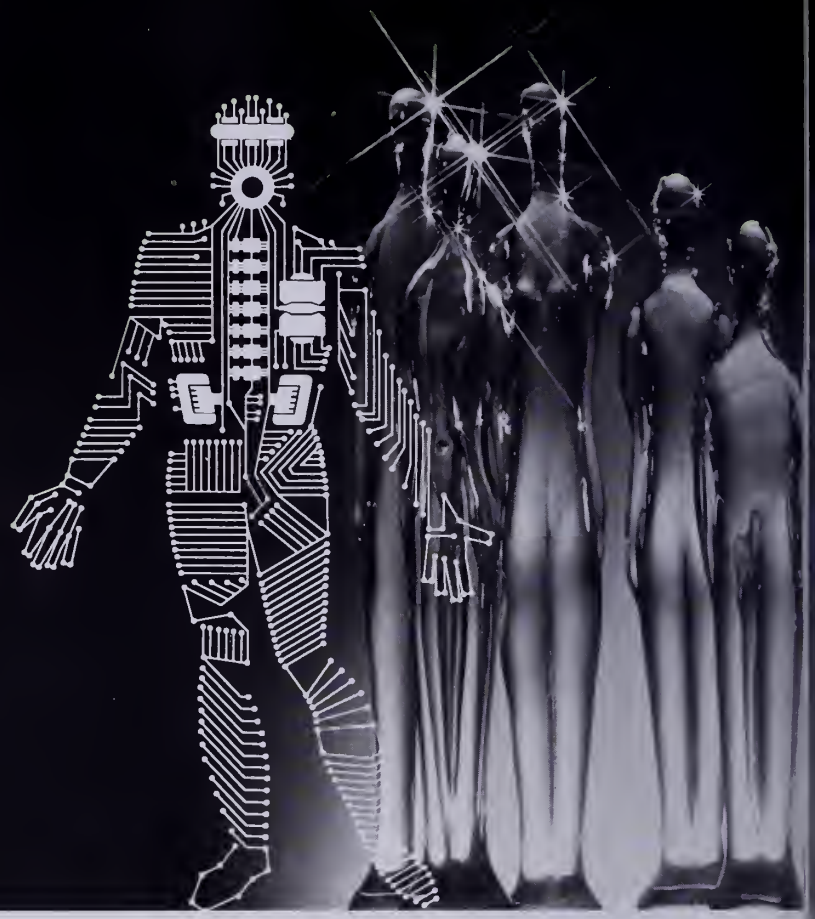


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Hypertension

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Hypertension

- No contraindications.
- Effective in all degrees of hypertension. It is mild to moderate in potency.
- Low incidence of depression, impotence, orthostatic hypotension—no fatal hepatotoxicity.
- Preserves kidney blood flow.

Most common side effects are dry mouth, drowsiness, and sedation which generally tend to diminish with time.

The usual starting dose of Catapres is 0.1 mg at bre fast and 0.1 mg at bedtime. Some patients may ben from a starting dose of 0.1 mg at bedtime.

Usual daily dose range—0.2—0.8 mg

Maximum daily dose—2.4 mg
Doses as high as this have rarely been employed.

For optimal results, the dose of Catapres must be adjusted according to the patient's individual blood pressure response.

Catapres®
(clonidine hydrochloride)
Tablets of 0.1, 0.2, 0.3 mg

Indication: The drug is indicated in the treatment of hypertension. As an antihypertensive drug, Catapres (clonidine hydrochloride) is mild to moderate in potency. It may be employed in a general treatment program with a diuretic and/or other antihypertensive agents as needed for proper patient response.

Warnings: Tolerance may develop in some patients necessitating a reevaluation of therapy.
Usage in Pregnancy: In view of embryotoxic findings in animals, and since information on possible adverse effects in pregnant women is limited to uncontrolled clinical data, the drug is not recommended in women who are or may become pregnant unless the potential benefits outweigh the potential risk to mother and fetus.
Usage in Children: No clinical experience is available with the use of Catapres (clonidine hydrochloride) in children.

Precautions: When discontinuing Catapres (clonidine hydrochloride), reduce the dose gradually over 2 to 4 days to avoid a possible rapid rise in blood pressure and associated subjective symptoms such as nervousness, agitation, and headache. Patients should be instructed not to discontinue therapy without consulting their physician. Rare instances of hypertensive encephalopathy and death have been recorded after cessation of clonidine hydrochloride therapy. A causal relationship has not been established in these cases. It has been demonstrated that an excessive rise in blood pressure, should it occur, can be reversed by resumption of clonidine hydrochloride therapy or by intravenous phentolamine. Patients who engage in potentially hazardous activities, such as operating machinery or driving, should be advised of the sedative effect. This drug may enhance the CNS-depressive effects of alcohol, barbiturates and other sedatives. Like any other agent lowering blood pressure, clonidine hydrochloride should be used with caution in patients with severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

As an integral part of their overall long-term care, patients treated with Catapres (clonidine hydrochloride) should receive periodic eye examinations. While, except for some dryness of the eyes, no drug-related abnormal ophthalmologic findings have been recorded with Catapres (clonidine hydrochloride), in several studies the drug produced a dose-dependent increase in the incidence and severity of spontaneously occurring retinal degeneration in albino rats treated for 6 mo longer.

Adverse Reactions: The most common reactions are dry mouth, drowsine sedation. Constipation, dizziness, headache, and fatigue have been re Generally these effects tend to diminish with continued therapy. The fo reactions have been associated with the drug, some of them rarely. (I instances an exact causal relationship has not been established.) These Anorexia, malaise, nausea, vomiting, parotid pain, mild transient abnorma liver function tests; one report of possible drug-induced hepatitis without and hyperbilirubinemia in a patient receiving clonidine hydrochloride thalidone and papaverine hydrochloride. Weight gain, transient elevation glucose, or serum creatine phosphokinase: congestive heart failure, Ra phenomenon; vivid dreams or nightmares, insomnia, other behavioral ch nervousness, restlessness, anxiety and mental depression. Also ra gioneurotic edema, hives, urticaria, thinning of the hair, pruritus not ass with a rash, impotence, urinary retention, increased sensitivity to alcohol, d itching or burning of the eyes, dryness of the nasal mucosa, pallor, gyneco weakly positive Coombs' test, asymptomatic electrocardiographic abnor manifested as Wenckebach period or ventricular trigeminy.

Overdosage: Profound hypotension, weakness, somnolence, diminishe sent reflexes and vomiting followed the accidental ingestion of Catapres (cl hydrochloride) by several children from 19 months to 5 years of age. lavage and administration of an analeptic and vasopressor led to comp covery within 24 hours. Tolazoline in intravenous doses of 10 mg at 30 intervals usually abolishes all effects of Catapres, (clonidine hydrochlorid dosage.

How Supplied: Catapres, brand of clonidine hydrochloride, is available as (tan) and 0.2 mg (orange) oval, single-scored tablets in bottles of 100 and 10 available as 0.3 mg (peach) oval, single-scored tablets in bottles of 100.

For complete details, please see full prescribing information.
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They're in their late sixties, the beneficiaries of more liberal retirement laws and more enlightened attitudes toward the elderly. They're leading socially productive lives. But recently, without any clear cause, they had each begun to experience mild episodes of symptoms such as confusion, mood-depression, and dizziness. Their ability to function could have been jeopardized. That's when they became the beneficiaries of oral Hydergine therapy.



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Oral Hydergine tablets promote better patient compliance

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Contraindications: Hypersensitivity to the drug.
Precautions: *Because the target symptoms are of unknown etiology, careful diagnosis should be attempted before prescribing Hydergine tablets and sublingual tablets.*
Adverse Reactions: Serious side effects have not been found. Some sublingual irritation, transient nausea, and gastric disturbances have been reported. Hydergine tablets and sublingual tablets do not possess the vasoconstrictor properties of natural ergot alkaloids.
Dosage and Administration: 1 mg three times daily. Alleviation of symptoms is usually gradual and results may not be observed for 3–4 weeks.
How Supplied: Hydergine tablets (for oral use) 1 mg, packages of 100 and 500. **Hydergine sublingual tablets 1 mg,** containing dihydroergocornine mesylate 0.333 mg, dihydroergocristine mesylate 0.333 mg, and dihydroergocryptine (dihydro-alpha-ergocryptine and dihydro-beta-ergocryptine in the proportion of 2:1) mesylate 0.333 mg, representing a total of 1 mg; packages of 100, 500, and 1000. **Hydergine sublingual tablets 0.5 mg,** containing dihydroergocornine mesylate 0.167 mg, dihydroergocristine mesylate 0.167 mg, and dihydroergocryptine (dihydro-alpha-ergocryptine and dihydro-beta-ergocryptine in the proportion of 2:1) mesylate 0.167 mg, representing a total of 0.5 mg; packages of 100 and 1000.
Before prescribing, see package insert for full product information.

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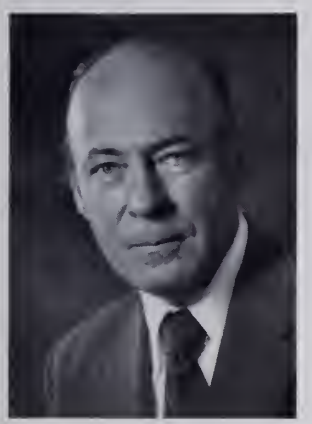
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Charles K. Donegan, M.D., . . . of St. Petersburg (right), was proclaimed "Citizen of the Day" in Gainesville on March 7. Mayor William Howard of Gainesville presents the proclamation while FMA Secretary **Robert E. Windom, M.D.,** (left) looks on. Dr. Donegan is a former Speaker of the FMA House of Delegates and is a Florida Delegate to the American Medical Association.



Dr. Murray

Louis C. Murray, M.D., of Orlando . . . has been appointed one of the six public representatives to the Board of Directors of Shands Teaching Hospital and Clinic, Inc., of Gainesville.

Dr. Murray is a former member of the Florida Board of Regents and is a Past President of the Florida Medical Association. He currently serves as Chairman of the Medical Advisory Committee to the University of Florida College of Medicine.

The Orlando physician's appointment was made by **Robert Q. Marston, M.D.,** President of the University and President of Shands Corporation. The 1979 State Legislature authorized the conversion of Shands from a state institution to a private, non-profit corporation.

Three Florida physicians . . . figured prominently in the 36th Annual Congress of the American College of Allergists at Bal Harbour, January 19-23.

Heading the list of Florida participants was **Sol Klotz, M.D.,** of Orlando, who was installed as President of the 2,000-member national specialty group.

Clive E. Roberson, M.D., of West Palm Beach, was designated as Chairman of the Committee on Pediatrics and a member of the Executive Committee and of the Nominating Committee. **Melvin Newman, M.D.,** of Jacksonville, was one of two members designated "Fellow Distinguished" of the College.

Dr. Newman was selected for the honor by the Scientific and Educational Council of the College for his contributions to the field of allergy practice and for his work in developing post graduate education programs for fellow clinicians.

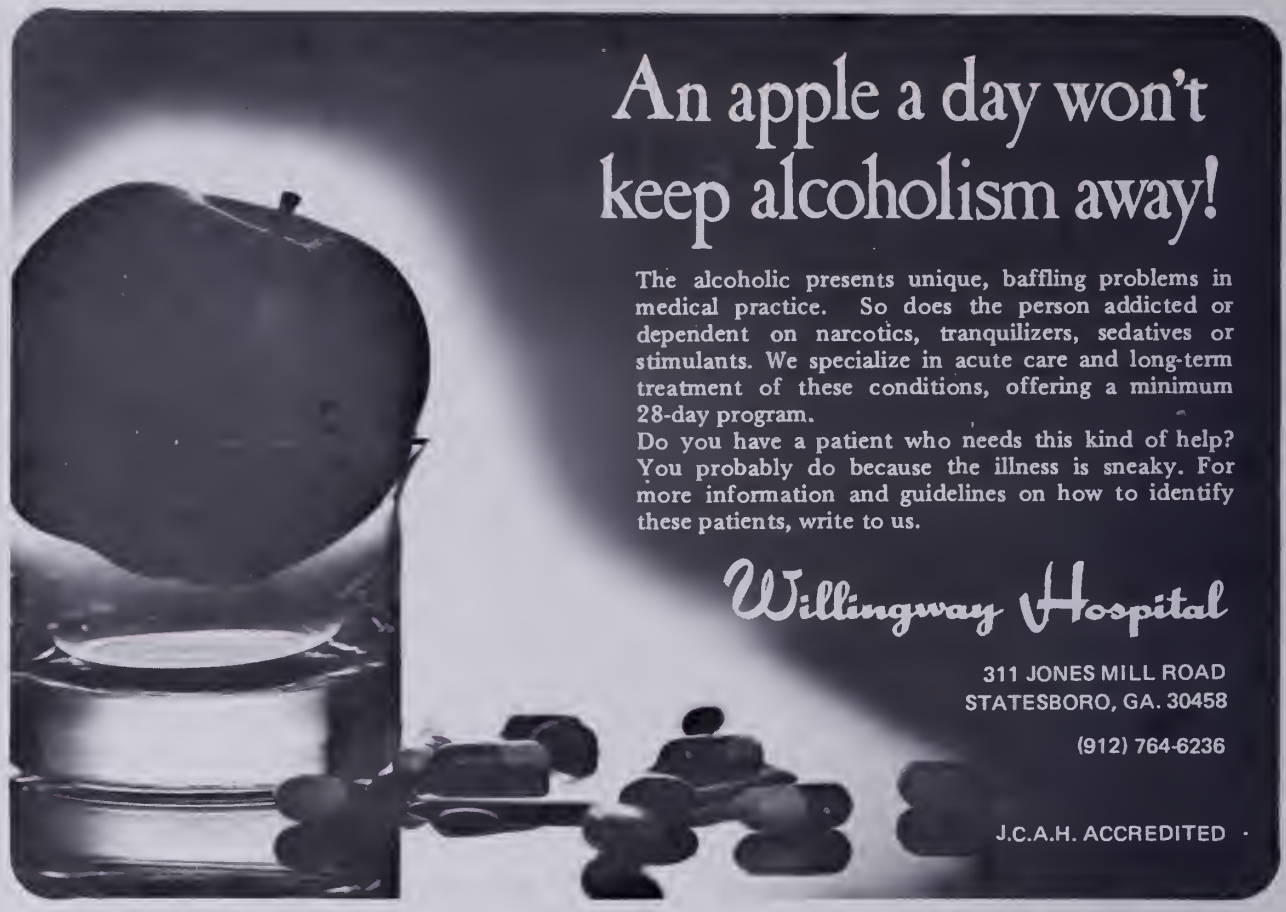
Entries in the 1980 Florida Medical Association for Excellence in Medical Journalism . . . are now being evaluated by a panel of three judges. Representing the medical profession is **Sanford A. Mullen, M.D.,** of Jacksonville, FMA Speaker of the House.

Assessing the material from the standpoint of production excellence and quality of writing are **Joe Dickerson** account executive with William Cook Advertising of Jacksonville, and **Edward A. Kennedy,** President of Communications 21 of Jacksonville.

The winners in the five designated categories will be announced during the 106th Annual Meeting in Hollywood.

Alfonso Vargas, M.D., of Tampa . . .has been awarded third prize in the Young Investigator's Award Program sponsored by the Southern Society for Pediatric Research.

Dr. Vargas, Assistant Professor of Pediatrics at the University of South Florida College of Medicine, entered research entitled "Effect of Triiodothyronine on the Metabolism of Vitamin D in the Hypophysectomized Male Albino Rat" with co-investigator **Allen W. Root, M.D.,** Professor of Pediatrics.



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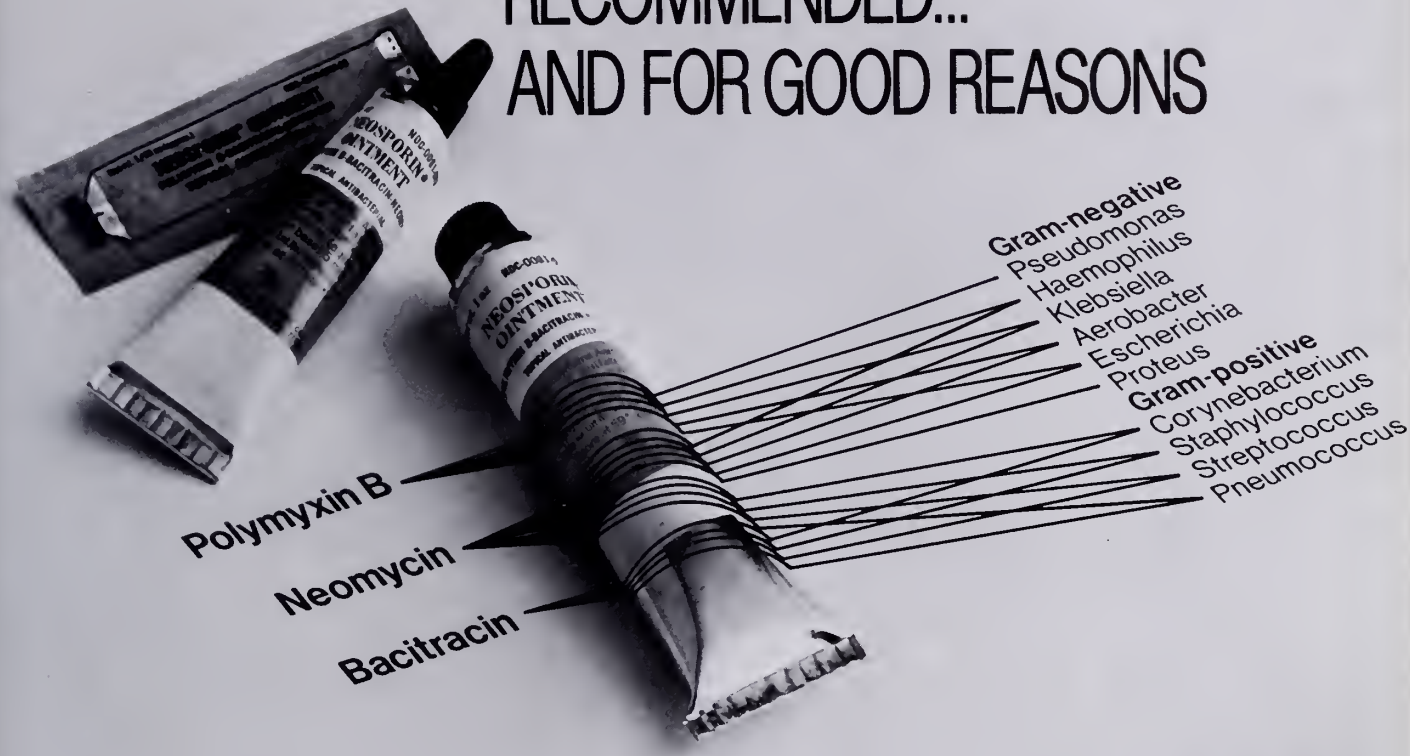
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WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

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INDICATION: For relief of constipation.

PATIENT WARNING: Should not be used in the presence of undiagnosed abdominal pain. Frequent or prolonged use without the direction of a physician is not recommended. Such use may lead to laxative dependence.

DIRECTIONS FOR USE—ADULTS: Before breakfast and after the evening meal, one to two rounded teaspoonfuls of Perdiem™ granules should be placed in the mouth and swallowed with a full glass of warm or cold beverage. Perdiem™ granules should not be chewed. After Perdiem™ takes effect (usually after 24 hours, but possibly not before 36-48 hours), reduce the morning and evening doses to one rounded teaspoonful. Subsequent doses should be adjusted after adequate laxation is obtained.

IN OBSTINATE CASES: Perdiem™ may be taken more frequently, up to two rounded teaspoonfuls every six hours.

FOR PATIENTS HABITUATED TO STRONG PURGATIVES: Two rounded teaspoonfuls of Perdiem™ in the morning and evening may be required along with half the usual dose of the purgative being used. The purgative should be discontinued as soon as possible and the dosage of Perdiem™ granules reduced when and if bowel tone shows lessened laxative dependence.

FOR COLOSTOMY PATIENTS: To ensure formed stools, give one to two rounded teaspoonfuls of Perdiem™ in the evening with warm liquid.

DURING PREGNANCY: Give one to two rounded teaspoonfuls each evening.

FOR CLINICAL REGULATION: For patients confined to bed, for those of inactive habits, and in the presence of cardiovascular disease where straining must be avoided, one rounded teaspoonful of Perdiem™ taken once or twice daily will provide regular bowel habits. Take with a full glass of water or beverage.

FOR CHILDREN: From age 7—11 years, give one rounded teaspoonful one to two times daily. From age 12 and older, give adult dosage.

NOTE: It is extremely important that Perdiem™ should be taken with a plentiful supply of liquid.

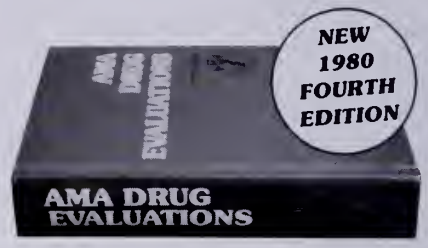
HOW SUPPLIED: Granules: 100 gram (3.5 oz) and 250 gram (8.8 oz) canisters.

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THE JOURNAL
OF THE FLORIDA MEDICAL ASSOCIATION INC
APRIL 1980
VOL 67 • NO. 4

Special Issue On Physical Fitness

Guest Editor

James B. Perry, M.D.

Co-Guest Editor
Rufus K. Broadaway, M.D.

Introduction



James B. Perry, M.D.

They come in all shapes and sizes and from all walks of life: pubescent schoolboys, spindle-legged girls, pot-bellied businessmen and dowdy housewives as well as better-assembled specimens of both sexes.

They are students, housekeepers, bankers, schoolteachers, government bureaucrats, electricians, plumbers, bus drivers, secretaries, beauticians, and doctors.

Depending on their particular bent, they inhabit the YMCA's, the health spas, golf courses, the handball courts, the tennis courts and the racquetball courts of the land. They have converted busy thoroughfares and sleepy residential streets into running trails as they jog to a particular cadence with either ease of gait or labored step toward a distant measured goal.

Whatever their methodology and whatever their motivation, all personify a national phenomenon: America is getting back in shape.

It is appropriate that the Florida Medical Association recognize this trend and make its own contribution through this Special Issue of its ***Journal*** *dedicated to Physical Fitness.*

It was less than one short year ago that the FMA Committee on Physical Fitness was charged with responsibility of preparing this issue in cooperation with Editor Gerold L. Schiebler, M.D., and his colleagues on the ***Journal*** *staff.*

We accepted the challenge and ran with it. With the help of many interested people we have produced this issue and commend it to you for your information and enjoyment. The Guest Editor would like to use this space to acknowledge those "doers" who contributed:

— Heartfelt thanks to all the authors from A (for Dr. Annis) to Z (for Dr. Zimmerman) whose fertile minds and expertise developed the material you will read hereafter.

— Grateful appreciation to my fellow members on the Committee on Physical Fitness, Rufus K. Broadaway, M.D., of Miami, and Howard K. Blankenship, M.D., of Tampa, and to our "boss", Joseph T. Ostroski, M.D., of Miami, Chairman of the FMA Council on Medical Services.

— Accolades to Stephen P. Glasser, M.D., of the University of South Florida College of Medicine; C. Richard Conti, M.D., of the University of Florida College of Medicine; and George Christakis, M.D., of the University of Miami School of Medicine for their excellent editing of the manuscripts.

— Sincere gratitude to the FMA Board of Governors and particularly to President Richard S. Hodes, M.D., and Executive Vice President W. Harold Parham, D.H.A., for their inspiration and guidance.



President's Page

Physical Fitness

A prominent jogger is reported to have dropped dead while taking his daily three miles. Another limps into orthopedists' office with severe tendon inflammatory disease. A hospital emergency room patient is admitted with complications of nutritional deficiency from a fad diet. The American Cancer Society advertises "How to Quit Smoking" kits for members of the medical profession.

These items illustrate a clear fact: That while physical fitness is clearly a concern of an increasing number of physicians and others, a vast amount of research and education on the subject is still required.

It has been a goal of the FMA in 1979-80 to use our public relations resources to educate the public to the concept of "wellness" and protection of good health through improved life style. Along with the promotion of life styles for health, we have the even greater responsibility to educate ourselves and our patients to the scientific principles of health maintenance.

Life style change certainly shouldn't include ill-advised exercise routines or poorly balanced fad diets. Physicians should inform themselves on counseling techniques in dealing with diet and the control of dangerous alcohol and tobacco habits. To do this it's important that the latest information on the causes and effects of poor living habits are readily available to us.

While common sense can dictate sensible exercise programs, it takes good patient workups and a knowledge orthopedic risks to advise routines.

To deal with all of this the FMA has taken on an ambitious program of public and physician education. This issue of *The Journal* and the Annual Meeting are part of a vigorous educational effort. No better response to the issue of health care and its cost could be made by the FMA. It is my hope that all of us will take advantage of our organization efforts. More importantly it is my hope that all Florida doctors will make the effort through the extensive literature available to inform themselves further in the realm of physical fitness.

If we in medicine can be clearly recognized as expert counselors on nutrition; exercise; sleep; drug, alcohol, and tobacco abuse and the other facets of staying well, the stature of the profession of medicine will be elevated. We should meet the challenge before us to serve our community not only with the heroic saving of lives but also the wise protection of health.

We have the opportunity to restore today's doctor to his true image of a concerned and caring friend of people. This we can do with active health counseling of patients and the public. All of this can be done simply with awareness and knowledge on our part without sacrificing a single thread of scientific medicine as we have come to know it.

A few extra minutes with a patient, an occassional club speech on health care, or media interview are efforts which will meet a proper public demand for doctors of medicine who demonstrate their concern for the preservation of health as well as its restoration.

We owe this much to our communities. We can give them no less.

Richard Hodes

American Lifestyles and Physical Fitness

T. Byron Thames, M.D.

The scientific theme of the Florida Medical Association for 1978-79 was Nutrition and culminated in an excellent scientific program and outstanding special issue of *The Journal of the Florida Medical Association* on this subject. It is a fitting corollary that this year's scientific theme is Physical Fitness.

Several years ago the Florida Medical Association produced a public relations film on Your Lifestyle—Is it Self Destructive? This film was given statewide exposure in prime time commercial television and has been shown to many civic groups throughout Florida. In addition, it has been utilized by many state schools as part of their health education for students. The film gave an excellent presentation of the health problems incurred by many Americans due to overeating, overdrinking, smoking and getting too little exercise. The movie emphasized that the mortality rate in the United States has dropped very little in the past few decades. The leading causes of death have changed from infectious diseases to strokes, heart attacks, vehicular accidents, homicides, suicides—all of which are related to our lifestyle.

The American Academy of Family Physicians published a report on Lifestyles/Personal Health Care in Different Occupations in 1979. It was a study of attitudes and practice among 4,500 workers in six occupations groups: 1) business executives; 2) family physicians; 3) farmers; 4) garment workers; 5) secretaries; 6) teachers.

The most significant finding to emerge from the study was that a majority of those studied were victims of stress on the job. The second discovery was that many of these people were unable to cope with workplace stress in a healthy manner. They reacted to this stress by excessive smoking, excessive drinking, excessive eating and, in some cases, to drug abuse. While many of these subjects expressed a desire to pursue healthful avenues for coping with stress, relatively few did so.

Many of you attempt to assist your patients to a better adjustment to work or personal stress by counseling them on nutrition, weight reduction, stopping smoking, decreasing reliance on drugs or medicines (prescribed or unprescribed), and healthy exercise programs. It is easier to prescribe a tranquilizer or antidepressant in a busy schedule than to take the time to listen to the patient's problems and help him or her understand the use and abuse of medication in working out a solution to a stressful situation. However, we all must continue to conscientiously pursue this educational process with our patients.

In discussing stress with your patients, some of the findings of the Lifestyles/Personal Health Care in Different Occupations may be helpful:

1) A leading cause of job unhappiness stemmed from a lack of appreciation at work—many people changed jobs for greater self-fulfillment rather than for a higher salary.

2) The work environment was reported to be more stressful than the home.

3) Talking to a friend was a leading means of coping with stress.

4) As job stress increased, it brought an increased incidence of allergies, migraine headaches, backaches, muscle aches, tension, nervousness and anxiety, smoking, drinking, and overeating.

5) Half or more of the occupational groups studied indicated they would like to lose weight but few reported dieting in the six months before the study.

6) Respondents to the study agreed that exercise was important to health but only a half to two-thirds of any group exercised twice a week or more.

7) Walking was a leading form of exercise reported by all groups.

8) Satisfaction with a doctor's services depended more on the physician's interest in the patient as a person than on his or her diagnosis and treatment of the disease.

Physicians were no different from other occupational groups in the generation of stress and their reactions in attempting to cope with it. How many of us espouse the cause of non-smoking and yet still personally participate? How many of us are overweight or drink more than we would recommend to our patients? How many of us call for increased exercise for our patients and yet fail to find the time for our own personal physical fitness program?

Our patients need us. Our colleagues need us. Most of all, our families need us. We must make greater efforts through programs like this one of the Florida Medical Association and that of the American Academy of Family Physicians to educate ourselves and our patients to the importance of a good lifestyle for better health and then we must participate fully as individuals.

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Physical Fitness: Fun and Games

Mrs. B. David Epstein

It is impossible to pick up a newspaper or magazine or walk into a book store without being impressed with the number and variety of materials dealing with physical fitness. Hopefully, this is not a passing fad. At long last we are becoming aware of the physical and emotional benefits of being physically fit. There are many definitions for physical fitness, some being strength, speed, muscular and cardiorespiratory endurance, flexibility and the overall feeling of well-being; but, whatever the definition, many times one's lifestyle must be changed and this usually includes a regimen of exercise, coupled with proper nutrition.

According to some recently published articles, exercise can do more than burn up a few calories. It can lift your spirits, trim your torso and even reduce your appetite. The best way to train in any sport is gradually; but, before proceeding with any diet plan or exercise regimen, one should see his personal physician. A moderate amount of exercise performed regularly is better than vigorous and strenuous activity performed erratically. Of course, it is essential to maintain proper body weight and exercise can burn off unneeded calories; but one must burn 3,500 calories to lose a pound of weight or exercise for 22 hours; so, it is far better and easier in the long run to change one's eating habits. The best diet is a balanced diet complete with the daily requirements of the five different kinds of nutrients. Special diets with emphasis on particular foods or vitamins or food supplements are expensive, hard to stay with and probably not very beneficial.

The latest statistic places over 60 million Americans participating in either jogging, running, tennis, squash, racketball, swimming or weightlifting. This does not include the millions involved in other sports or exercise, but the most startling discovery is the number of women of all ages actively participating. Not too long ago when a woman packed away her baggy green gym shorts, that signaled the end to her more active physical involvement. Not so today. Women can and do participate in every kind of sport and exercise known to man. From aerobic to isometric she can tailor a program to her personality and needs. She can exercise alone or with a group, to music or during meditation. The varieties are endless.

Most of us are dedicated to the work ethic and it is surprising how being physically fit can enhance our time devoted to work. If we enjoy exercise and apply the same principles to working we then in turn enjoy our job more with less stress. Part of physical fitness includes psychological benefits such as lowering tension and depression and increasing one's capacity for stress management. The discipline of exercise can spill over to all areas of one's life.

In keeping with the Florida Medical Association's priority on physical fitness, lifestyle and nutrition, the Auxiliary has adopted the American Medical Association Auxiliary's *"Shape Up for Life"* program. Posters and brochures have been distributed throughout the country. TV and radio spots have been aired regularly. This is an ongoing campaign to educate and motivate the American public to the necessity of changing one's lifestyle to achieve physical fitness.

Now we come to a touchy area. The most powerful influence on a husband is his wife and this applies to doctor husbands as well. We can help our spouses stay in shape by gentle persuasion. It is only our care and concern that motivates us to look after his health. Almost all sports and exercises can be enjoyed with one's spouse and some positive attitudes can be the result. Competition can be fun and can serve as an example for family and friends. So, doctor, get up from that chair, throw away those cigarettes, grab your mate instead of your plate and head for the courts or links or open road and enjoy. You certainly will add more life to your years and possibly more years to your life.

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Physical Fitness and The Sick Doctor

George S. Palmer, M.D.

The Practice of medicine and all of the governmental, regulatory, legislative, public, personal demands and expectations exert tremendous physical and mental demands on a physician. The physician must often be all things to all people. Generally speaking, the persons who survive the rigors and intense pressures and competitive environment of college pre-med, admission to medical school, medical school and postgraduate residency training are very intelligent, highly motivated, obsessive, compulsive persons with a great deal of self confidence and ego. Once in practice, a good physician is assured of almost instant financial success and most of his patients make him feel that they are highly dependent upon him and therefore he may get the feeling that he is indispensable. Because of all of the above mentioned factors some physicians work too hard and too long, do not take enough time for physical and mental relaxation, time for themselves and their families and therefore become victims of their professional position and success.

Into this picture come the three D's, DRUGS, DRINKING and DOMESTIC DIFFICULTIES. The end result is a physician who takes either drugs, alcohol or both to keep going and to escape the pressures and problems of practice and personal life. He/she is reluctant to admit the problem, is very hesitant to go to anyone about it and things progress inexorably to some sort of tragedy or injury to a patient. The physician finally comes before the Board of Medical Examiners in very bad shape. The main function of the Board is to protect the public. These disabled physicians at this stage are both a danger to themselves and to the public and therefore must be removed from practice in the public interest first, and in the physican's interest second. The loss of that precious license to practice his profession is another tragedy and a blow to his ego, self-image and security. It is unfortunately necessary in order to "get his attention" and make him be serious about the rehabilitative process. Rehabilitation involves abstinence from the drugs and/or alcohol which caused the inability to practice with safety to patients as the absolute first requirement. Then comes restoration of physical, mental and emotional wellbeing and along with this restoration of confidence and professional competence. This requires psychotherapy, often medical, surgical and physical therapy, family support, change in bad habits, life-style and developing the ability to relax in many ways other than by using drugs, alcohol or being a difficult, authoritarian, obnoxious, overbearing, egocentric personality and prima donna. Avoiding smoking, overeating and excess in any physically or mentally deleterious activity is most important. Often the physician must go to an institution specializing in the rehabilitation of disabled physicians if he is fortunate to have one available. When he/she and those active in the rehabilitative process feel that the physician is able to assume practice competently and with safety to patients the physician may petition the Board for restoration of his license. The burden of proof is upon him to convince the Board that this should be done. The license is rarely completely restored right off, but restrictions are placed upon the physican such as probation (generally for five years), restrictions on prescribing controlled substances, practice under supervision or in a structured environment. If he has been out of practice for a long period there may be CME requirements. This road for the disabled physican is long and difficult with disappointments, frustration, resentment, often hostility, humiliation, sometimes tragedy, recognition and admission of the problem, support and then motivation for rehabilitation. Public and legislative expectations are now quite clear that unfit physicans must be discovered, reported, removed and dealt with effectively and efficiently either by their peers or by the Board of Medical Examiners.

What is the best solution? The theme of this special issue of JFMA clearly suggests the answer. Ideally, if every physician practiced what he preaches he would keep physically, mentally and emotionally fit. Voila, no disabled physicians. The ideal is rarely attained and physicians are structurally, physiologically and chemically no different from other mortals. The realistic solution is prevention by peer and family support, understanding and earlier willingness to correct the situation. This is where a program for disabled physicians is so valuable as a preventive solution. Call it what you will—Big Brother Committee, Committee for Physician's Well

The Author

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Being, Sick Doctor Committee, Disabled Physician's Committee—if such help is available on the local level and on the state level in organized medicine and the members are ready, willing and able to discover, confront, convince, deal with and correct the problem then this is preventive medicine and maintaining physical and mental fitness in its finest sense. This will further be preventive in avoiding the final blow as previously described of confrontation with the Board of Medical Examiners. I think that we have as a profession been deficient in the past in this terrifically important aspect of maintaining physical and mental fitness (and therefore competence) in ourselves and fellow physicians. In the theme of this issue of the JFMA we should and must recognize this deficiency and its extreme importance to each one of us and do everything we can to correct it.

The physician who keeps himself/herself physically, mentally, morally and ethically fit and who therefore maintains his competence is the physician who also has the trust and confidence of his patients and who reflects credit upon himself and the medical profession.

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Exercise? I Will Have No Part Of It!

James T. Cook Jr., M.D.

I strongly contend that letting the general public loose with all those exercise programs, with the acquiescence and even the encouragement of misguided athletes in the medical profession, is a hazard to the gullible public. I will have no part of it.

When the President of the United States, presumably one of the most intelligent men in our nation, permits himself to become physically exhausted to the point of collapse . . . and no one could disagree that this is not the recommended end-point of exercise for the middle aged man . . . one cannot help but wonder how competent is the athletic judgment of those with lesser intellect.

The Author

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I also object to my ozone being deteriorated by the constant spray of Right Guard© insufflated into the armpits of jocks all over the nation. Admittedly, the ingredients have been changed . . . but so has the nicotine content of my cigarettes. Unpublished, unsubstantiated preliminary statistics reveal that five times as much deodorant is used by these people as is released by us of more sedentary heart . . . with a comparable end result.

Pounding my ear and my derriere, eating too much, smoking too much and indulging in other deplorable habits has resulted in a vast gain in strength in my own case. Twenty-five years ago I could barely lift $40,000 in gold. Today, given the opportunity, I could easily lift $400,000 worth.

So much for physical fitness.

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Exercise and Coronary Artery Disease

Stephen P. Glasser, M.D., F.A.C.C., F.A.C.P.

Concerning the mode of treatment by which the body and mind are to be preserved — moderate exercise reduces to order, according to their affinities, the particles and affections which are wandering about the body.

— Plato

In 490 B.C., an outnumbered Athenian army defeated the invading Persians in an historically decisive battle on the plains of Marathon. The Athenian general sent his swiftest runner (Pheidippides) to annouce the victory to the city. The runner, weary from a recent run in excess of 160 km (100 mi.) and dressed in full armor, raced the approximate distance of 42 km (26 mi.) from the battle to the city of Athens and gasped the news of victory. Exhausted, but his task completed, he fell to the ground dead. Conflicting reports as to the actual identity of the runner, and even the veracity of the fatal event, have since appeared. Even in 490 B.C., myth and disagreement obscured the issues. Today, controversy still surrounds the benefits and limitations of exercise.

The acute and chronic effects of exercise on cardiopulmonary function in normal subjects are discussed in accompanying articles in this journal. These same effects, in general, apply to the patient with coronary artery disease although the direct cardiac benefits are obviously limited by the amount of myocardial scarring. But the questions to be asked and still awaiting answers relative to the subject of exercise in coronary artery disease are, does exercise prevent the occurrence and/or expression of coronary artery disease and do exercise rehabilitation programs effect the natural history of the patient with symptomatic coronary artery disease?

Modern day investigation of the benefits of exercise probably begins with the epidemiologic study of Morris[1] in 1953, when he demonstrated a markedly reduced coronary death rate among London bus conductors when compared to the more sedentary bus drivers. In a followup study, decreased coronary death rate was also found in London postmen, when compared to age and sex matched postal clerks. A number of retrospective epidemiologic studies have since emerged,[2-10] almost all of which have demonstrated reduced coronary events in active versus sedentary population groups (Table I).

Fewer prospective epidemiologic studies have been performed (Table II)[11-19] but the study by Paffenbarger et al[11] is exemplary. They followed two groups of San Franciso longshoremen (groups whose jobs were separated by different energy expenditures) and found fatal myocardial infarctions in the active men to be one-half to one-third that of less active men in all age groups. The difference in death rates between "high" and "low" energy output workers was most evident for the sudden death syndrome. Grouping for other risk factors did not affect this trend. In another study by Paffenbarger,[20] the morbidity and mortality data of Harvard alumni were investigated. The energy expenditure of this group was quantitated by noting the 24 hour activities which included stairs climbed, city blocks walked, and leisure time participation in light or vigorous sports play. Heart attack risk was noted to be reduced as physical activity increased. A 16 percent reduction in risk was estimated when physical activity expenditure was 2000 K cal per week, a 30 percent reduction at 4000 K cal per week, and a 36 percent reduction at 5000 K cal per week. In contrast, one comprehensive study, a multicenter cooperative effort in which over 12,000 subjects were evaluated, failed to demonstrate any benefit from exercise.[13] All of these studies have obvious limitations, defects in design, etc., and, therefore, are of questionable validity; but, although these are appropriate criticisms, I submit that they are the same types of criticisms that can be aimed at the vast majority of studies extolling the virtues of aorto-coronary myocardial revascularization procedures.

If exercise does prevent the appearance of progression of atherosclerotic heart disease, one might ask "by what mechanism(s)?" Eckstein's[20] study in dogs is perhaps the most quoted in regard to exercise and a resultant increase in myocardial blood flow via an increase in collateral supply. They produced surgical constriction of the circumflex coronary artery in dogs.

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Table I. — Retrospective Epidemiology Studies — Physical Activity and Coronary Heart Disease (CHD)

	Population Size	Correlation of Inactivity to CHD
Morris[1]	31,000	Yes
Zukel[2]	30,000	Yes
Taylor[3]	100,000	Yes
Hames[4]	5,000	Yes
Frank[5]	301	Yes
Stamler[6]	1,500	Yes
Prout[7]	172	No
Schnohr[8]	307	No
Pomeroy[9]		No
Polednak[10]	681	No

Table II. — Prospective Epidemiology Studies — Physical Activity and Coronary Heart Disease (CHD)

	Population Size	Correlation of Inactivity to CHD
Paffenbarger[11]	3,300	Yes
Kannel[12]	5,000	Yes
Keys (7 countries)[13]	12,000	No
Werko[14]	834	Yes
Morris[15]	16,882	Yes
Pathology		
Morris[16]	3,800	Yes
Rehabilitation		
Gottheiner[17]	1,103	Positive Trend
Hellerstein[18]	100	Postive Trend
Rechnitzer[19]	68	Positive Trend

One group of animals subsequently underwent two months of regular exercise, while the other group were maintained at rest. At a second thoracotomy in both groups the circumflex coronary artery was cannulated proximally and distally to the constriction, and antegrade and retrograde flow was measured. The results demonstrated that the amount of retrograde flow was proportional to the constriction, suggesting that the greater the constriction, the greater were the collaterals. Several anecdotal human cineangiographic human studies have been since reported that have failed to demonstrate an increase in coronary collaterals following an exercise program.[21] It should be apparent, however, that failure to demonstrate collateral vessels by such a crude technique as angiography is not sufficient, even if enough scientifically studied patients were available. On the other hand, since Eckstein's original report, a number of studies have suggested improved myocardial blood flow following a chronic exercise program. Redwood et al[22] carefully studied a group of patients with angina pectoris before and after participation in an exercise program, and found that the triple product (heart rate X blood pressure X systolic ejection time — a measure of myocardial oxygen consumption) at the point of angina was increased in most after physical conditioning. This suggested an increase in myocardial oxygen delivery. In a study of exercised dogs with surgically induced coronary artery constrictions, Heaton et al[23] investigated regional myocardial blood flow using radioactive microspheres and demonstrated improved subendocardial myocardial blood flow in dogs. Both studies supported Eckstein's original study. Other authors, such as Ferguson et al,[24] however, suggest that the mechanism of improvement in cardiac performance is a reduction in 0_2 requirements for a given workload, rather than improved collateral flow. Indirect evidence for improved coronary flow is also suggested by an increased in capillary to muscle fiber ratio in exercised animals versus sedentary controls[25] and enlarged coronary arteries in those animals exercised[26] (studies stimulated by the finding of larger than normal coronary arteries during a postmortem examination of Clarence DeMar,[27] one of the earliest popular marathon runners who died of cancer at the age of 66, one year after running his 100th marathon). Rose et al[28] in a human postmortem study found a 75 percent greater cross-sectional area in portions of coronary arteries that were free from plaques in those who were heavy workers, compared to those who were engaged in less active occupations during life.

Given the continued controversy of these studies and the effects of exercise on the development and/or progression of coronary artery disease, what can be said about the effect of exercise in patients with known coronary artery disease? In 1972, Heberden published a clinical description of coronary heart disease, and first noted the beneficial effects of exercise in a patient for whom he prescribed a six month period of sawing wood for one-half hour per day, a treatment that all but "abolished his recurrent chest discomfort." In 1799, Parry demonstrated that patients with angina were benefited by activity, but these observations were all but ignored until the 1960s, when Gottheiner started an active reconditioning program in Israel for patients with coronary heart disease. Since, a number of cardiac rehabilitation programs have been established. What is known definitely about these programs is that they are safe[29] (a recent multicenter survey of 1,480,000 man

hours of participation reported 37 nonfatal cardiac arrests and 14 fatal events — i.e., one cardiac arrest per 29,020 man hours with 80 percent successful resuscitation, Table III) that a resultant decrease in anginal frequency occurs in 70 to 80 percent of participants in such programs return to the productive work force with the same or greater frequency when compared to standard medical or surgical therapy.[31] (Table IV)

Although still uncertain, participation in such programs may also result in lower recurrent myocardial infarction rates and coronary mortality. Sanne et al[32] randomized 316 postmyocardial infarction patients into two groups. One group was placed in an exercise rehabilitation program and the other group underwent standard postinfarction rehabilitation. Six month coronary mortality was 6 of 156 in the training group versus 18 of 160 in the control group (p 0.025). Rechnitzer et al[19] also reported favorable results of physical training in men with previous documented myocardial infarctions (Table V). Weaknesses of both studies, of course, exist. For instance, it was not possible to quantitate activity or lack of activity in the "control" group, and it is difficult to separate out other risk factor modifications (smoking, diet, etc.) in the exercise versus the control group. It is also not known if those individuals who enter a medically supervised exercise program and persist in it are not inherently different to begin with than the "controls" or drop outs. A National Exercise and Heart Disease Project (NEHDP) was initiated in 1972 in hopes of solving some of the conflicting issues. It is currently ongoing, and the results should be available in several years.

In 1978, because of the information available to that date, a cooperative effort on the parts of the University of South Florida, its College of Education and College of Medicine, a number of Tampa Bay area hospitals, area physicians and area business persons formed a nonprofit corporaton called the Tampa Bay Cardiac Prevention and Rehabilitation Program (TBCP). From its meager beginning on the grounds and in the gymnasium of the University of South FLorida, when three individuals (and a glassy eyed physician) presented themselves at 6:30 a.m. for supervised exercise, the program had grown to almost 100 subjects by January, 1979. From April, 1978 to April, 1979, 97 individuals had enrolled in our group B (individuals with no known coronary disease) and 40 in our group A (cardiac patients). In Tables VI and VII, data are presented for the group A patients.

One of the first patients was most interesting. He was a 60-year-old dentist, two years postsubendocardial myocardial infarction. Coronary angiography had revealed inoperable two vessel disease. He had difficulty returning to his work because of symptoms of fatigue. Treadmill testing on three different occasions were similar to the treadmill test obtained upon entrance into our exercise program (Figure 1) and demonstrated 2-3 mm horizontal S-T depression at heart rates of 130-140 beats per minute. After three months of supervised exercise, he had progressed to 20 minutes of continuous jogging, without symptoms. He no longer complained of easy fatigability and had returned to his dental practice on a part time basis. Repeat treadmill testing (Figure 2) showed longer exercise duration and no S-T changes despite the higher heart rate achieved.

Table III. — Safety of Exercise Programs

Thirty Medically Supervised Outpatient Cardiac Exercise Programs

United States and Canada[29]

1,480,000 man hours' participation

37 non-fatal cardiac arrests

14 fatal events

1 major event/29,020 man hours

80% successful resuscitation

Table IV. — Medical Versus Surgical Therapy Return to Work*

	Med Rx	Surg Rx
Working 3 months prior to cath or surgery	74%	75%
Working 1 year post cath or surgery	62%	62%

No difference — education, FTC, 2 or 3 VD, median vs. heavy work

*From: Hammermeister et al
American Journal of Cardiology, 1978[31]

Table V. — Rehabilitation — Effect on CHD**

	Non-fatal Recurrence ***	Cardiac Deaths
Exercise Group (77)	1.3%	3.9%
Matched Control (111)*	28%	11.8*

*Not true controls

**Not risk factor matched

***Poor documentation

From: Rechnitzer[19]

Table VI. — Tampa Bay Cardiac Program

Background Data (Group A — see text)

Age 39 - 70 (mean age 53)

Duration in program 3 mo. — 12 mo. (mean 6 mo.)

Cardiac diagnoses:

myocardial infarction	17
symptomatic post AC bypass	18
angina	4
post valve replacement	1
other	8

(e.g., hypertension, cardiomyopathy, asymptomatic positive treadmill test)

Table VII. — Complications — Tampa Bay Cardiac Program

(Estimated Man Hours' Observation — 2000)

"shin splints"	0*
cardiac arrests	0
myocardial infarction	2
(Neither during exercise)	
inability to continue	
because of angina	2
(One was referred for AC bypass)	
arrhythmias	1

*severe enough to stop exercise

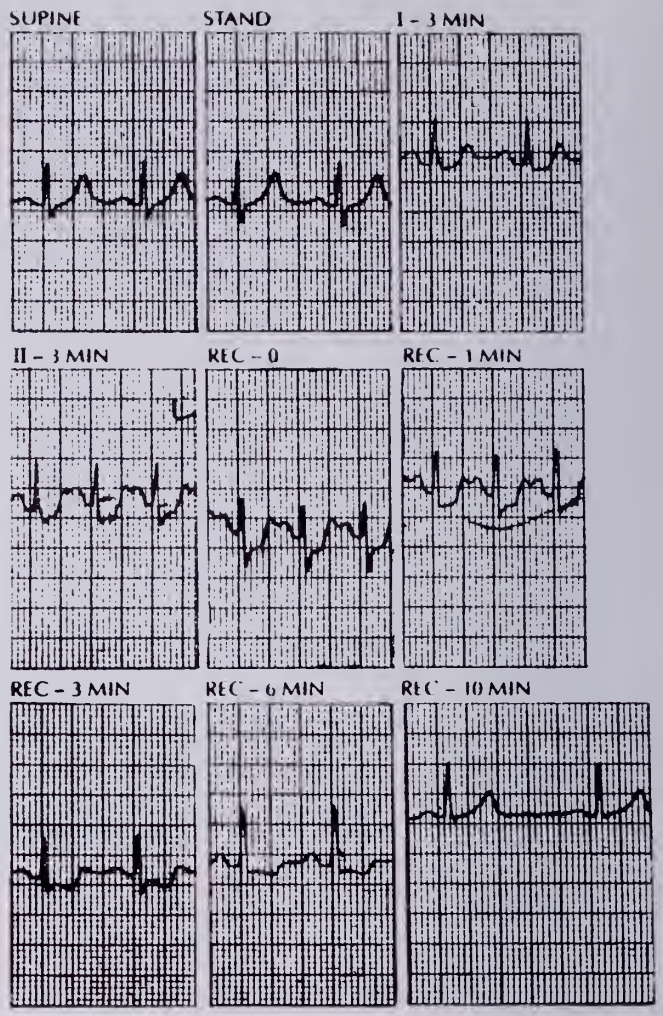


Fig. 1. — The treadmill test of a 60-year-old dentist with inoperable coronary artery disease prior to entrance into an exercise program. The Bruce Protocol was used. I = Stage I, II = Stage II, REC = Recovery Period, MIN — Minutes (Reprinted with permission, Glasser, S.P.; Clark, P.I.: The Clinical Approach to Exercise Testing, Hagerstown: Harper & Row, forthcoming.)

In summary, as in 490 B.C., controversy surrounds the virtues of exercise. A number of epidemiologic retrospective and prospective studies, animal studies and human studies at least suggest a possible protective effect upon the progression of expression of coronary heart disease. What is known for sure is that in the majority of patients, the quality of life and myocardial efficiency (as measured by a lower heart rate necessary for a given workload after than before training) is almost universally improved. In comparing regular, endurance dynamic exercise to aortocoronary bypass surgery, (Table VIII) I feel it is fair to say that each has been similarly studied. But, even the most enthusiastic proponent of surgery would not suggest that myocardial revascularization procedures attack the underlying cause of atherosclerosis or prevent atherosclerotic progression (indeed, it is well known that there is acceleration of the atherosclerotic process in the vessels proximal to a bypass). Although it remains unproven, exercise may influence the appearance of progression of the atherosclerotic process. Finally, the cost of A-C bypass across the country is in the range of $10,000 to $15,000, while most rehabilitation programs cost less than $1,000 per year. (The exercise sessions in the Tampa Bay Program cost less than $700 per year). The intent of this article is not, however, to discuss bypass surgery — clearly, it is of benefit in selected patients — but, rather, to emphasize the value and safety of exercise in patients with coronary artery disease. One should also consider the potential additive effects and possible modification of atherosclerotic progression in patients who have undergone aortocoronary bypass.

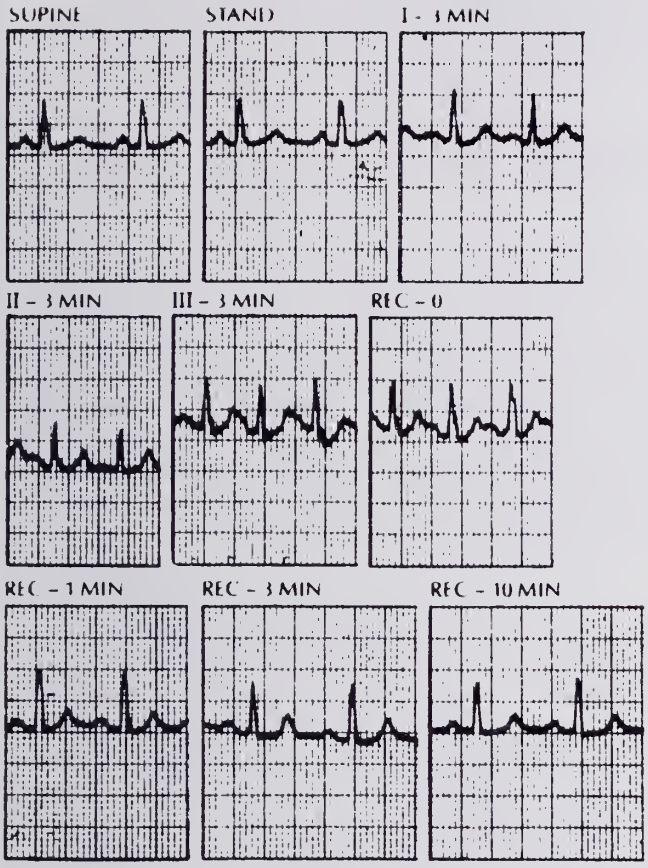


Fig. 2. — The treadmill test of the same patient shown in Figure 1 three months after an aerobic training program (see Text). Same abbreviations as Figure 1 (Reprinted with permission, Glasser, S.P.; Clark, P.I.: The Clinical Approach to Exercise Testing. Hagerstown: Harper & Row, forthcoming.)

Table VIII. — Comparison of Exercise and Aortocoronary Bypass

	A-C Bypass	Exercise
Number of Patients Carefully Studied	5000	5000
Symptomatic Relief	75 - 80%	75 - 80%
Prolongation of Survival	Unknown	Unknown
Attacks Underlying Cause	No	Unknown
Prevents Atherosclerotic Progression	No	Unknown
Expense	$15,000 + First Year	$1,000 Per Year

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Some Mental Aspects of Physical Fitness

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As an addicted runner, I agreed to write on this subject in spite of a reluctance analoguous to A. E. Housman's observation: "Even when poetry has a meaning, as it usually has, it may be inadvisable to draw it out . . . perfect understanding will sometimes almost extinguish pleasure".[1] We are always apprehensive that an analysis of any enjoyable activity will dilute our pleasure.

A centipede was happy quite,
Until a frog, in fun, said
Pray which leg comes after which?
This raised the bug to such a pitch
He lay distracted in a ditch
Considering how to run.

A psychiatrist has been defined as a person who is only interested in things that are none of his business. I think I can escape criticism on this score, because running definitely is some of my business; however, it may well be more difficult for me to evade the allegation that nothing is so simple that a psychiatrist can't complicate it.

Physical activity is essential for physical health. This is an inevitable consequence of biomechanical man having evolved over at least the last two million years with complex interlocking systems enabling him to survive stresses by being an active creature. Our primitive ancestors roamed the earth using all their physical capabilities. If we represent an estimated two million years of man's being on this earth by one hour on a clock, the last one hundred years consists of only one fifth of a second. Prior to "one second ago" there were no mechanical transportation devices, few roads, no factories, and very little in the way of refined foods. Within this brief "one second" man's physical environment has been subdued. When there are rapid changes in the environment and the organism does not change, the organism is destroyed. Man still has a body with included neuropsychiatric apparatus similar to what he had two million years ago. Now he is spared many physical stresses and actually relieved of physical outlets for emotional stresses. He gets into a car to drive one block to a cocktail party. He complains if the electrical can opener isn't working. He enjoys relief from even the stress of fevers. He is relatively secure. Food is always there to be used non-nutritionally to exceed his caloric requirements. He is insulated within a narrow range from changes in the weather. These luxuries contribute to his lack of positive physical health and to some hypokinetic diseases as the wages of biological sin.

Adaptation to his environment formerly required physical activities. It is only in the last industrialized century or two that he can survive without dynamic physical health. The active use of his inherited physical equipment is necessary for him to attain self realization. Beyond the muscular benefits of dexterity, oxygen uptake, and strength are psychological experiences sought by mankind. Man, the player (Homo Ludens)[2] seeks sport and play. He may go to great expense to be entangled in games which captivate him. The complexity of the human brain drives man to seek symbolic satisfaction as well as physical outlets. He has been labeled "animal symbolicum"[3] because the brain, as that great quantitatively unique "third system" between receptor and effector outlets, impels him to seek physical and spiritual satiety in that intriguing gap between his being "a little higher than the apes and a little lower than the angels."

Physical fitness is not just "good" for you. It is also a mental "good" arising from a fundamental unity and inseparability of the mental and physical. The real meaning of the concept of "psychosomatic" is not "psychogenic," but rather one of indivisible linkage implied in Plato's observation that "any defect of the psyche or soma is the occasion of the greatest discord and disproportion in the other."

The confinement of industrialized urban civilization leads to "emotion without motion," and stifles our "action absorbs anxiety" therapeutic maneuvers. We actually need even more outlets for the relief of tension in an urban society because of the infusion of the distillate of intercultural stresses (displosion) and confusing technological overload (technoplosion) into our lives.[4]

Physical activity results in mental benefits not only by producing a strong physical executive apparatus but also an awareness of a strong mental executive apparatus. Physical fitness games usually also supply us

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with the abstract "vitamin" of play. A recognition of the need for play seems necessary to comprehend many of the antics, hobbies, obsessions, preoccupations and diversions of individuals and groups. The fulfillment of the need for play and games offers a felicitous avenue toward the attainment of both mental and physical equilibrium. Unlike other adult animals, man continues to play. It is as if man needs diversion from his sense of the world's being too complex and limitless. He seems to have compelling needs to seek relief and a sense of mastery and importance by playing in a smaller "ball park." Here he finds during a siesta from "reality," a refuge from being forced to cope with an infinitely vast, blurred, confusing world. He seeks something better regulated and relatively comprehensible.

Johann Huizenga, in his study of the ubiquity of play elements in culture, perceives the following characteristics of play to be subtly disparate from "real life":

Free activity (free or leisure time)
Voluntary (not obligatory)
Outside ordinary (real) life
Fixed rules (freely accepted but absolutely binding) and orderly manner
Absorbing — requiring intense attention
Unproductive — no material interest (no "nut gathering" or increase in net worth)
Definite time and space boundaries
Promotion of social groups with "secrets" and "in-group" knowledge
End in itself — the game itself and the diversion is the reward

What a revitalizing contrast with the social and economic necessities of "real life"! The need for such relief makes play a continual ingredient of man's experience. In fact, everything outside of "play" from religion to work seems to go better with some admixture of play.

In this Olympic year of 1980, there are some expressions that games are over-exalted. But to demand elimination of games in which somebody wins, and to insist upon only games in which there can be no winner, seems to be a psychological construct which unrealistically denies pathways for man to express drives constructively as well as to face his limitations humbly.

Achieving excellence and winning can be respectfully sought without guilt despite their being extolled as everything or the only thing. Winning is an acceptable occasional ingredient in our diet, even though "the essential thing is not to have conquered but to have fought well." (Baron Pierre Coubertin—founder of the Olympic Games).

The physical activities of sports allows us safe opportunities to overcome challenges, adapt to others, and inevitably be confronted by our own limitations. These experiences are rungs on a ladder of opportunity to approach maturity and ultimate humility. Even if such an ideal is not obtained, sustained involvement and a degree of relative mastery of a physical sport such as running commonly leads to a sense of being in charge or control of one's life as well as producing a sense of physical well being. Exercise is nature's own tranquilizer. The experience of physical integrity is our first line of defense against anxiety.

Movement experiences leading to physical fitness improve the body image and lay a basis for a greater margin of psychic safety. It is important to foster physical fitness in youth to assist in preventing obesity and a concordant negative body image. During the sensitive years of adolescence obesity may result in a sense of contempt for one's body. This psychological damage is relatively resistant to change. Continued "middle age spread" may be attenuated much more easily by the adult who has a positive memory of what he was and can be. The reward of returning to this positive image is then seen as attainable. Thus the self discipline required to achieve an optimum body weight is more easily exercised. The body image is never completed. It is always changeable to some extent. Therefore, physical activity throughout all decades is to be encouraged.

The "ego" is first of all a "body ego." The capacity to meet physical stress results in feelings of security. A sense of mastery accompanies the maintenance of cardiovascular fitness and muscular performance. This feeling of being Mr. Fit certainly contrasts with the anxiety of "having my life in the hands of anyone who makes me mad" and not being able to utilize the avenue of relief of anxiety through action. Testimonials to the benefits of running may be more anecdotal than scientifically satisfying, but aerobic physical fitness programs are certainly more antidotal than the putative benefits of physical activities confined to "serving as a pall bearer for one's friends who exercise."

Individuals seek risk and stress varying with their somatotypes and temperaments. Some are satisfied by watching the activities of others. Some of our schoolmates were more interested in the preliminaries of choosing up sides than they were in actually getting into the game. They probably became our well needed adult organizers and phone chairmen. These individuals also need personally acceptable sports pathways to physical fitness. They need **EU**-stress. Eustress (not dys-stress) is characterized by exertion within one's limits of acceptability, accompanied and followed by euphoria, excitement, and a catalytic enhancement and replenishment of one's vital energies. Eustress produces the "natural high" and is not followed by "crashing and burning."

It is the task of physical educators to teach physical activities without inducing either boredom or burnout. The goal is to have a "flow experience" wherein the stresses are self applied and optimally matched with aptitudes. Thus, dystress and anxiety are avoided.

Forcing some distance runner types into the combat of contact sports seems to be counterproductive. If one sport or physical activity is dissonant to a personality, he should be exposed to sports more acceptable to his self perception. Different strokes for different folks.

Exposure, therefore, to a wide spectrum of moderately strenuous participant exercise regimes should be a part of our culture. *Mens sana in corpore sano* should be the harvest of an increased probability of any individual's experiencing rewards and successes and, therefore, maintaining physical fitness as a component part of his entire life.

It is equivocal whether there is any definite evidence that intensely competitive athletics generally makes, on balance, positive contributions to personality development. Certainly, many mental health benefits can accrue from physical fitness achieved without such rigors.

Coronary heart disease jogger program participants almost always claim they "feel better." Regular joggers also usually claim they feel better, but note that these are people usually involved with mild to moderate exercise regimes. High level trainers always have aches and pains and don't necessarily "feel" any better than they did prior to such high level strain.

Fortunately, it is true that many runners, though faithful to their discipline of healthful hardship, run only as they enjoy it and not to the point of actual physical breakdown and exhausted frustration. I have seen no evidence that extending running beyond four or five times a week and twenty-five to thirty miles a week actually contributes, over time, to any significant increase in physical or emotional benefit. Of course it is true that more training than this is necessary to achieve competitive excellence to win races or to attain maximal physical performance. However, I believe that there is truth in the observation that the psychophysiological state of capacity to win or achievement of maximal physical performance is perilously close to anatomical, physiological and psychological breakdown.

The runner profits from keeping a goal of a balanced life in mind and not becoming the fanatic who redoubles his efforts after he has forgotten his aim. No great idea is responsible for all the fanatics who cluster around it. Physical fitness programs involving jogging are of course no panacea but they are a great idea and we should continue to support such programs.

There is no validated data that running is better than any other individually accepted aerobic physical exercise. The important thing is that the program be one that the individual compliantly pursues. My personal feeling is that not only running but any physical fitness regime which is optimally modulated (eustress) is usually beneficial to health. This includes walking. The individual returns to being first of all a good animal. The benefit probably arises by way of a stabilization of an otherwise unbalanced life.

There have been studies demonstrating that running has been temporarily associated with improvement in such emotional conditions as depression. However, treatment programs of any type — even tincture of time — show improvement with such syndromes. There are no controlled studies comparing running with other modalities of treatment which show any impressive significant superiority of running as a treatment.

As good doctors we should pungently repudiate running as a panacea. Some publications have apotheosized running as a cure for all mental and physical infirmities. Running has been invested as the royal road to philosophico-religious omniscience. "I ran through the five boroughs of New York City and found God." Such bursts of hyperbole reek certainly of a transient cultism. There are always votaries of any "hobby" or "game" who are unable to understand why everyone doesn't share their personal enthusiasms. When the pendulum returns it will pass a mid-point indicating some lasting value of jogging or running.

Running does have definite benefits including: (1) psychomotor expression without the hazards of contact sport and therefore throughout our life lying regularly within our grasp with less chance of injury to self or others, (2) resultant physiological health to set the stage for our first defense against anxiety, i.e., physical integrity and (3) its being the most flexible, economical aerobic activity adaptable to the widest spectrum of weather, geography, time tables, personalities and body types. Despite relative simplicity and minimal necessity for decision, running offers for many a "jock" status at a particular time of life when our culture tends to over civilize man into a cocktail party decadence.

It is difficult to find any more universally acceptable program than jogging. Swimming, bicycling, and practically all sports have their aerobic equivalents; however, their hazards, expense, and the time involved are comparatively greater. Running can be social or asocial, independent or dependent, organized or unorganized, actively chattering or in splendid isolation, as dramatic as "streaking" or as covert as running down the back roads at night. It can be acceptably modified by each individual according to his unique characteristics.

Life Style and Coronary Artery Disease

The compulsive time-bound Type A personality has in some quarters been related to the development of

coronary artery disease. Which is the better remedy? Should we try to change the personality or offer the person an efficient change in lifestyle which a running program or its equivalent may supply? A definitive answer is not possible at present; however, it is my opinion that it is idealistic and overly naive to expect that compulsive preoccupation and obsession with time (type A-squared personality) will be eradicated or even greatly modified via time consuming psychotherapy. It is probably more reality-oriented to encourage the type A personality to engage in a kind of physical program to which he can be compliant without disrupting his penchant for efficiency and productivity during "the time of his life." We will probably be more successful in having him accept a jogging program than we will be successful in having him modify deeply rooted personality traits. People's personalities don't change much and the compulsive type A personality is usually rewarded in our culture.

A word about addiction to running. Addiction to running is characterized by an uneasiness when the run is omitted or delayed. This may in part be due to the threat of a loss of invincibility. Runners have a sense of immunity to cardiac disease that is part of a sense of invulnerability. Omitting the run may mean that this protective activity is being neglected. As long as the run is completed the runner sees himself safely under the umbrella of one of the Ur-defenses.[5] He affects a cloak of invulnerability and protected significance. Rather than impotently and passively sensing himself to be an insignificant speck in an indifferent universe, he would rather believe in his physical immunity or at least relative resistance to death from coronary disease. Embracing such a myth testifies to a "need to believe." If such evangelical endorsements of immortality for runners were actually affecting actuarial tables, no faithful addicted runner would be able to buy retirement annuities. Insurance companies would refuse to obligate themselves for everlasting indemnity.

Nevertheless, common sense tells us to seek a balance. Modern medicine, over the past forty years has emphasized the beneficial effects of a healthy mind on the body. Isn't it time that all physicians, and especially psychiatrists, direct more attention to what a well (and not just undiseased) body may do for the mind? Let us, as members of the medical profession, cooperate with all disciplines to find ways for exercise to be enjoyable, rewarding, stimulating, and promoted with minimal hazard and injury.

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Heat and the Runner

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Last March in Sarasota there was a 10,000 meter "fun run," one of 15 or so such runs during the year. A 35 year old attorney who had been running seriously for about a year was eager to set a personal record and beat one of the veteran runners whom he had never beaten before. The attorney was well conditioned and had run his recent 10,000 meter races in about 42 to 43 minutes, a six minute and 50 second per mile pace. The day was cool and fairly dry with temperature in the low seventies. At four miles he was averaging about six minutes and 20 second miles and at that point another runner noticed that he had defecated. At the five mile point he was 200 yards ahead of the man he was trying to beat, when he picked up his pace for the last mile. With three-quarters of a mile to go, he suddenly collapsed falling forward onto the pavement. He was comatose, hot, sweaty, with fecal-stained shorts. After a six day hospital stay he has gradually returned to normal. There was a two month hiatus before he resumed his running and he has

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returned to his former level of training. He has decided not to push beyond that limit.

This case is typical of exertional heatstroke as described in novice and even well-trained runners. As more individuals are pushing themselves to run competitively, there are increasing numbers of such reports.[1,2] This paper will describe how the body gets rid of heat during long distance running. It will describe what happens when the body's coping mechanisms are overtaxed, and it will show how one treats heat-related problems. Finally, and most importantly, it will describe how one can prevent heat-related problems during running.

Heat Production

Heat is a waste product that is generated when the body burns fuel for energy. During intensive exercise such as long distance running, the energy demands of the exercising muscles increase tremendously. Heat production from this activity may increase as much as 15 times or more, when compared to the resting or basal state.[3] If there were no way to get rid of this heat, the body core temperature would rise 1°C or 1.8°F every five minutes.[4] A well-trained marathon runner will maintain a body core temperature of about 40°C (104°F), and this temperature will remain constant during two to three hours of running.[4] Clearly, there must be highly efficient mechanisms for the body to excrete the waste heat that is produced and there is a delicate balance between heat production and heat excretion.

The major source of heat is from muscular work. The energy production for this work can result from one of two types of metabolic reactions, aerobic or anaerobic. Aerobic metabolism is by far the more efficient, generating less heat than anaerobic metabolism for the same amount of energy production. If one considers only the heat produced by aerobic metabolism, a 60 kg runner would produce 900kcal per hour. If there were no way to get rid of this heat, core body temperature would rise to 45°C (113°F) within 30 minutes.

In addition to the muscular or endogenous source of heat, there may be exogenous sources of heat. The most important source of heat outside the body is solar radiant energy. During extreme conditions such as a sunny, clear day, the body may absorb heat amounting to 20% of that heat produced by the muscles themselves.[5] These conditions were typical of the Mexico City Olympics which took place at high altitude when there was little atmospheric haze to reflect the sunlight. However, most of the heat of running is generated from within the body and almost all of this heat is eventually excreted through the skin, with only about five per cent being excreted through the lungs.[3]

Heat Excretion

In order for heat to be excreted through the skin, it must be carried from the place where it originates. This transfer of heat is accomplished by the blood vessels and heart. Blood containing heat is carried from the muscles by the venous drainage. It is carried to the heart and pumped to the blood vessels under the skin's surface. When one compares the maximally vasoconstricted and the maximally vasodilated states, blood flow to the skin can vary by as much as twenty times.[3] As one exercises, the cardiac output reaches a fixed level. At this point, blood flow to the skin is regulated primarily by the degree of vasodilation. However, the skin must compete with the exercising muscles and the other vital organs for its share of the blood flow, and this occurs in the presence of a shrinking circulating volume due to the loss of fluid through sweating.[6]

Once the heat is carried to the skin by way of the bloodflow, it must be excreted. This occurs by one of several mechanisms. First, the body may radiate heat. This is not very important except when the temperature of the air is low. In fact, the body is more likely to gain heat at its surface by radiation from the sun. Secondly, heat may be carried away from the body surface by moving air, and this process is called convection. Heat loss by convection depends on air flowing over the body surface and it also depends on the temperature of the air flowing over the body. The movement of air over the body is determined by the wind speed and the wind direction, as well as the speed and direction of the runner. If one runs at 9 miles per hour, with a 9 mile per hour tail wind, there will be no net movement of air over the body. If one runs at 9 miles per hour on a still day, air will move over the body at 9 miles per hour. Of course if one runs into a 9 mile per hour head wind, air will move over the body at 18 miles per hour. In addition, there will be a trade off since less energy is required to run with a tail wind so that a little less heat is generated. Convective heat loss is a major factor at moderate and cool temperatures, when the surrounding air is less than 80°F.[5] Certainly any barrier such as insulating clothing will reduce convective heat loss. As the ambient air temperature rises, convection becomes relatively less important as a way to lose body heat.

The last major way for the skin to excrete heat is by evaporation. Each cc of water that evaporates from the skin carries 0.6 kcal of heat away.[3] If a 130 pound man ran a marathon in two hours and 40 minutes, and if all of the heat that was generated were carried away by the evaporation of sweat, that man would lose about four liters of body fluid.[4] This would be about eight pounds or about 6% of his body weight. In fact much of the sweat that is produced never evaporates at all, but merely drips to the ground, so that it is "wasted."

The major factors that determine how much heat is lost by evaporation are the amount of skin surface that is

wetted and the ability of the sweat to evaporate. If one wears heavy clothing or a garment that is impermeable to sweat like a plastic or nylon sweatsuit, then less body surface will be available for evaporation. The less that the runner is covered, the more effective evaporation will be.

High relative humidity and low airflow will inhibit evaporation. Every runner has experienced being drenched by sweat during a still humid day. If the sweat cannot evaporate, it will not cool the skin and the blood beneath the surface of the skin. Precious body water in the form of sweat will drip to the ground resulting in fluid loss with little cooling activity.

Summary

In summary, heat production in the runner depends on the following factors: First there is the degree of exertion and muscular work, that is how hard the runner is pushing him or herself. Second, solar radiation may add heat to the runner's body depending on atmospheric conditions and the time of day. Third, the level of fitness will determine how efficient is the runner's metabolism. The runner that is better trained will generate energy for the muscles more efficiently with less heat production than a poorly trained runner.

Factors that may limit how well a runner can excrete heat are as follows. First, blood volume must be adequate to supply the muscles with nutrients and to supply the cutaneous circulation so that heat can be excreted at the same time that it is being generated. Second, sweat must be produced and enough skin surface must be exposed for both convective and evaporative heat loss. Third, the sweat must be able to evaporate and when it is more humid or the relative airflow is slight, evaporation may be limited. Finally, as the air temperature rises, heat loss by convection and radiation is less effective, and when the temperature is in the mid-eighties or above, almost all of the body's heat is lost by evaporation of sweat.[3]

Adaptation to Heat

As every runner knows, one can adapt to warm and humid conditions. This can occur in a relatively short period of time, generally in about four or five days.[8] This occurs in a variety of ways. First, with training *per se*, one's metabolism becomes more efficient. By running long distances, the capacity for aerobic metabolism increases as the number and size of mitochondria in the exercising muscles increase.[9] Thus, less heat is generated as the body becomes more efficient in its metabolism. In addition blood flow to the exercising muscles and to the skin improves so that the body as an integrated machine functions more efficiently.[10]

With training in the heat, plasma volume gradually increases and this provides a reserve supply of water for sweating.[7] In addition sweating itself becomes more efficient. With training in the heat, sweating becomes more appropriate in the sense that it occurs only when it is needed.[12] Most people have experienced less sweating with the same degree of activity as one acclimates to the heat. In addition, the sweat itself becomes more dilute so that sodium and potassium are conserved.[7]

Heat - Induced Illness

Several conditions can arise if the body is not able to compensate fully for the stresses of heat production.

The least threatening condition that may occur is heat cramps. Actually, the term "heat" cramps is a misnomer since the painful skeletal muscle cramping is not due to heat *per se*. The cramps that occur in the exercising muscles are actually due to a local electrolyte deficiency resulting from excessive water and sodium loss.[8] Heat cramps are more likely to occur in a well-conditioned individual, since that person is able to sustain a greater fluid and sodium loss than a poorly-conditioned person. This condition can be truly disabling, but it responds readily to oral or intravenous salt solutions.

Heat exhaustion is characterized by fatigue, weakness, elevated body temperature, dehydration, but not loss of consciousness.[8] The runner with heat exhaustion may also complain of nausea and may have muscular cramps as well. Treatment of heat exhaustion consists of cooling the runner and replacing fluid and electrolytes. Usually all one needs to do is put the runner in the shade and give an electrolyte replacement solution. The runner may be taken to a cooler environment and even given intravenous fluids, preferably saline or five per cent dextrose and half-normal saline. It should not be necessary to apply ice packs to the runner.[8]

Heat stroke is a progression from heat exhaustion. The difference is that the runner has collapsed and has been unconscious.[1,2] Rectal temperature may be as high as 42.5°C (108.5°F). The runner with heatstroke is likely to be sweating, even though the body's cooling mechanisms have been overwhelmed, so the presence or absence of sweating is not an important diagnostic factor.[2] the key factor is loss of consciousness and collapse. The runner may have lost sphincter control. The runner may be hypotensive and may even have had a seizure.[2,8] Hypoglycemia may also complicate the acute picture.[2]

Heat stroke often occurs in runners who are highly motivated.[2] They tend to extend themselves while they ignore the body's warning signals. Heat stroke is more likely to occur under conditions of high temperature and high humidity, but it may also occur during cooler and drier conditions.[1,2,4] In novice runners, collapse from heat stroke can occur near the finish within minutes after the pace has been accelerated. This was described in several runners who had trained at a 7½ to 8½ minute per mile pace. During the last several thousand meters of runs

ranging from 10,000 meters to a full 26 mile marathon, each had attempted to accelerate and hold a 6 to 6½ minute per mile pace. Each runner collapsed within 1000 m of the finish line.[2]

Heat stroke requires immediate action. The patient must be cooled immediately until the rectal temperature reaches 39°C (102.2°F). This usually requires packing with ice or some sort of cooling bath. Return to consciousness is closely related to the time required to cool the runner.[2] Intravenous fluids consisting of normal saline or other near isotonic fluids should be administered. Diffuse intravascular coagulation can occur, and renal failure may complicate the long term picture.

Prevention of Heat Illness

Heat-related problems can be very serious. Unfortunately they are occurring more and more frequently as more and more people participate in long distance running. In many cases problems can be minimized or prevented entirely.

Races should not be held under extreme conditions. The American College of Sportsmedicine has advised that races not be conducted when wet-bulb temperature index exceeds 82°F.[12] In addition if the daylight dry-bulb temperature exceeds 80°F, races should be run either before 9 AM or after 4 PM.[12]

Fluids should be taken prophylactically. Up to a liter and at least 500 cc of water or a hypotonic solution should be taken thirty to sixty minutes before running. Fluid must also be replaced as often as possible during the run. Usually one can take only 150 to 200 cc at a time during race conditions, but even that amount is helpful. The runner must try to minimize the fluid deficit since it is unlikely that he will be able to fully replace it during the run.[12]

One should not run under extreme conditions of heat and humidity unless one is acclimated. This can be achieved by training for four to five days in the heat. It can also be achieved by training in cooler weather while wearing a sweatsuit.[11] One must be cautious in doing this, though.

Finally, one should maximize cooling by wearing as few clothes as possible. This will be dictated by good taste and local statute. Furthermore, the clothes should be light and porous. A hat should also be worn to minimize absorption of heat on a sunny day.

It is our responsibility as runners to protect ourselves from heat disorders. In addition it is our responsibility as race organizers to inform participants of potential problems and to provide emergency care should the need arise.

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The scientist in neither an 'ant', storing what it finds lying about ready-made, nor a 'spider', spinning a web out of what its entrails secrete. He is a bee, visiting innumerable flowers and collecting the nectar it finds in them; but storing not this nectar in its crude state but the honey into which it turns.

Francis Bacon
Novum Organum, I. XCV

Exercise: A Worthwhile Prescription?

R. L. Bohannon, M.D.

In ancient Greece Hippocrates maintained, "Exercise is man's best medicine." This dictum suggests that, without great knowledge of exercise physiology, he was nevertheless aware of the physiological and psychological benefits of appropriate physical activity. The philosopher Montaigne was a runner 400 years ago. Though he had very little supporting scientific data, he recognized "the close connection between the mind and the body, whose fortunes affect one another," and maintained that many physiological and psychological changes are interdependent. Even our own Navajo Indians used to tell their children, "Run in the morning; and you'll be lively all day," thus implying impact on both body and mind.

The salutary effects of "appropriate physical activity," mentioned above, are those of aerobic exercise, which is characterized by continuous, steady-state exertion that can be carried on for 15 to 60 minutes or longer without stopping to catch the breath and repay the body's accumulated oxygen debt. Aerobic exercise is that which builds cardiopulmonary endurance, by increasing the body's oxygen-consumption capacity. The modern principal aerobic exercises include walking, running, swimming, bicycling. The physiological benefits of regular aerobic exercise are gradually achieving wider and wider corroboration in research reports: lower resting heart rate, more efficient cardiopulmonary functioning, higher levels of fitness and performance (as measured on treadmill or bicycle stress tests), and a lipoprotein profile consistent with a low risk for development of the manifestations of coronary artery disease. Aerobically active people tend to have lower blood pressure, lower blood cholesterol and triglyceride levels, and tend to be less fat. Thus the American Heart Association recommends physical activity as an adjunct to control measures aimed at obesity elevated blood lipids, and hypertension. Such exercise programs should be tailored to "the capacity and the interest of the individual patient," and should be combined with low-fat diets and cessation of smoking.

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Research during the past five years indicates an inverse relationship between blood levels of high-density lipoprotein and the incidence of coronary heart disease. Exercise training has been shown to increase significantly the high-density lipoprotein concentration. Descriptive studies have shown HDL concentrations to be higher in middle-aged men who habitually engage in running, jogging, and cross-country skiing. Thus regular endurance activity over a prolonged period appears to elevate HDL.

Recently the psychological effects of regular aerobic exercise have begun to receive studious attention and analysis. These effects range from "feeling better" to experiencing the "runner's high," in which, after a prolonged run, the subject becomes unmindful of pain and discomfort and becomes euphoric. It is at the "feeling better" stage, the enhanced self-image, sense of calm well-being and greater confidence of accomplishment, that the medical prescription for physical activity should aim.

The moderate and healthful psychological effects of running are described by Joan Ullyot, MD, of San Francisco, in the Jan. 25th issue of AMERICAN MEDICAL NEWS: "It cleared up my headaches and insomnia. I'm more vigorous; I've increased my energy and shrunk my dress size" . . . "Running tends to make women feel more self-confident and assertive . . . Running is a great way to relieve stress. 90% of the diseases physicians see are lifestyle diseases caused by smoking, overeating, overdrinking, and being sedentary. People need to take greater responsibility for their lives." "Running changed mine."

Dr. Earl G. Solomon, consultant in psychiatry at Massachusetts General Hospital, reported in the AMERICAN: JOURNAL OF PSYCHOTHERAPY (Oct., 1978) that slow long-distance running, combined with practical meditation, can be an important therapeutic approach even to the unrest felt by psychotic patients. "Jogging promoted a self-controlled, temporary, and healthful regression, and, in certain instances, it was clearly identifiable as the primary factor in the success of the treatment." James F. Fixx, author of THE COMPLETE BOOK OF RUNNING, has stated it this way: "Something in running has a uniquely salutary effect on the human mind."

The many benefits of aerobic exercise, both physiological and psychological, suggest that it is worthy

of being prescribed for many patients who appear to be free from disease but who, nevertheless, present with various aches and pains, with chronic fatigue, lack of energy, and loss of the zest for living. In a recent issue of the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION, the editor acknowledged, "Jogging does improve exercise tolerance, physical performance, and, most important, the quality of life. It generates a sense of fitness . . . in a subjective sense of restored self-confidence, of feeling young again, of being 'back in the run' "

Those who cannot learn to enjoy jogging, at least moderately, should turn to other forms of aerobic exercise, such as swimming, bicycling even walking, rather than giving up altogether and resigning themselves permanently to a life of inactivity. For walking will confer a good training effect if it is done briskly, frequently, and long enough at a time.

The jogging movement in the U.S. is now teen-aged. Inevitably, it has spawned its dissenters. They cite the injuries, traffic hazards, inconvenience, heart attacks, or even death. Many far-fetched, even imaginary dangers have been viewed with alarm: i.e., "dropped stomach," "fallen kidney," hernia, detached retina, "sagging womb," etc. It seems highly significant that supporting data are missing. In the meantime, research corroborates the benefits, among them the declining mortality from heart disease. Although other factors have operated, it is likely that the great increase in physical activity across the country deserves some of the credit.

Cooper has pointed out that in a study of 1600 men, mostly low mileage joggers, coronary risk factors declined as levels of fitness improved. Hartung studied the risk factors for coronary heart disease in 22 joggers, 22 marathoners, and 22 sedentary men. Total cholesterol was lower among both joggers and marathoners than in the sedentary group. The level of HDL cholesterol was 50% higher in the two running groups than in the sedentary group. Interestingly, there was no significant difference between the joggers and the marathoners in any risk factor studied except for the resting heart rate, which averaged eight beats per minute slower in marathoners. It appears that one doesn't have to run marathons in order to get some help against the coronary risk factors.

Aerobic exercise is not a panacea; but its benefits should be offered in specific prescription form to sedentary patients whose complaints, especially as they become older, derive from the effects of prolonged physical inactivity. After walking, jogging is the simplest, most economical, accessible, and easily regulated form of aerobic activity for the average sedentary American. (Only properly supportive footwear is the single absolute requirement.)

Precautions are indicated before any sedentary person undertakes a strenuous physical activity program. The best advice is that such persons should seek medical consultation from an exercise-oriented physician regarding any problem, musculo-skeletal or cardiopulmonary, and submit to a stress test under electrocardiographic monitoring. And every inactive person should begin an exercise program slowly—and work up only gradually to more strenuous activity, getting medical consultation along the way for any untoward symptom.

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Physical Fitness, Obesity and Diabetes Mellitus

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There is little doubt that most Americans are desirous of being physically fit. Those who have looked into the future have found that it may profoundly affect their health. Webster defines "fit" as being adapted to the environment so as to be capable of surviving.[1] The importance of medicine and physical exercise is not new. The need for exercise has been stressed in writing as old as 3000 years B.C.[2]

For more than 1000 years man had to be physically active; his life and livelihood depended upon it. However, man is endowed not only with brawn, but with a brain that has enabled him to harness the energy of animals, steam,

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internal combustion, and the atom. As a result, Western man uses much less muscle power than did his ancestors and less than people who still live without access to these energy sources. Facts demonstrate that most Americans are not in good physical condition. A California pathologist has stated that on the basis of autopsy studies he has performed, two out of every three deaths are premature, related to what he terms "loafer's heart," "smoker's lung," and "drinker's liver." Studies also show American children are not in good physical condition. A Massachusetts study of fifth graders found that only 15% were fit enough to win the Presidential Physical Fitness Award and, in Connecticut, 5% qualified. A Massachusetts General Hospital study revealed 15% of seventh graders sampled had high cholesterol and 8% had elevated blood pressures. With a decrease in physical activity, there has been noted a parallel increase in diseases such as arteriosclerosis, obesity, hypertension, and diabetes.

Exercise and Body Composition

Fitness involves a number of components. Primarily, it involves body composition and the body's response to specified activities.

After the first year of life and especially at the time of puberty there is a progressive increase in the percentage of body mass that is made up of fat. Women have a greater percentage of body mass, as fat, than do men of comparable age.[3] Skeletal muscle constitutes 40% of the body's oxygen consumption in the resting state. Exercise evokes an increase in consumption and utilization of oxygen and metabolic fuels to provide adenosine triphosphate necessary for muscle contraction. The average American diet provides 40% calories as carbohydrates and 40% as fat. Body fuel stores are almost entirely fat (80-85%), and this is even greater in obesity. This is in contrast to 1% in the form of glucose and 15-20% as protein. Energy needs of exercise are substantially dependent upon mobilization of free fatty acids, stored carbohydrates (muscle glycogen), and blood borne glucose. Early in exercise, muscle glycogen is the major fuel consumed. As exercise continues beyond 10 to 40 minutes, glucose uptake by muscle rises, approximately 7-20 times basal depending upon intensity of activity. As exercise continues there is a depletion of glycogen stores and a progressive utilization of fatty acids. The overall pattern of fuel utilization is a triphasic response in which muscle glycogen, glucose, and free fatty acids successively predominate as substrates.[4] Hormonally, the response to exercise is characterized by a fall in insulin and a rise in plasma glucagon.[4,5] The fall in insulin during severe exercise occurs despite a rise in blood glucose. Data indicate that insulin may have a permissive effect for uptake of glucose in exercising muscle.[6] Further, in contracting muscle, a humoral substance ("muscle activity factor") that stimulates glucose utilization by resting as well as exercising muscle, has been identified.[4]

The post-exercise recovery period is characterized by further increases in substrate requirement to insure replenishment of muscle and liver glycogen utilized during exercise. The influence of exercise on substrate requirement may last for 24 to 48 hours following prolonged and strenuous exercise.

Obesity and Physical Fitness

Estimates are that 10-50 million Americans are obese or overweight. Overweight is an increase in body weight over and above an arbitrary standard usually defined in relationship to height. Obesity, however, refers to an abnormally high proportion of body fat.[3] Being physically fit is incompatible with obesity.

Why the concern about obesity? Statistics from life insurance companies in 1959 demonstrated that excess weight was associated with an increase in mortality for both men and women. Based on 1979 data, an increase of 10% above the average weight is associated with a decrease in life expectancy of 11% in men and 7% in women. With a 20% increase in body weight, men have a 20% increased mortality and women 10%. This excessive mortality is caused by diabetes mellitus (3-4 times greater than nonobese population), gallbladder disease (2-3 times), and cardiovascular-renal disease (1-2 times). Obesity affects a number of organ systems. This is reflected in an increase in cardiac work and heart size, which is reversible upon weight loss, an association with hypertension, pulmonary function, and endocrine function. These effects occur with as little as 10% increase over ideal body weight but become significantly more important with a 30% excess in body weight.[7]

The problem of obesity is one of energy balance. Excessive caloric intake relative to caloric expenditure leads at various rates to the excessive storage of fat in the body. Obesity may be classified in numerous ways. One approach is a division based upon the anatomic characteristics of adipose tissue (i.e., size and number of adipose cells) at a given age of onset.[8] Another utilizes an etiologic classification encompassing hypothalmic, endocrine, nutritional, environmental, genetic, and drug etiologies.[4]

There are many reasons why individuals attempt to lose weight—vanity and social acceptance being high on the list. Other more cogent motives deal with concern over the greater risk of developing disease. Treatment of obesity involves a high degree of patient and physician motivation to achieve and maintain weight loss. The final decision resides with the patient. Those who will regain their weight make up the majority. The likelihood of one maintaining a 40 pound weight loss for 5 years

approximates that of surviving cancer of the stomach for 5 years.[3] Patients with obesity should be evaluated with a good history and physical examination in order to ascertain a possible etiology for this problem. Next, appropriate laboratory studies should be completed to evaluate glucose tolerance, lipid status, and uric acid. One might also consider gallbladder ultrasonography and cardiovascular fitness measurements. Algorithm's are available for reference.[7] Once these evaluations are complete, assessment of the extent of obesity should follow. This would include an estimate of ideal body weight or mass by using appropriate tables or normograms and, if applicable, a measurement of skinfold thickness. When ideal body weight has been ascertained, goals of the weight loss program may be explained. A person must have a caloric deficit of 3500 calories to lose 1 pound of fat. A realistic weight loss goal is 1-2 pounds per week. A diet with appropriate caloric restriction with the number of feedings suitable for that patient is then selected. This is coupled with a program of exercise that is again tailored to the patient and his or her health problems, other than obesity.

Physical inactivity is an important factor in the development of obesity in a high percentage of patients. Individuals have certain metabolic requirements. First is a requirement to maintain basal metabolism, which is slightly lower for women than men, and, in general, approximately 1000 calories a day per square meter of body area. Second are heat losses resulting from losses secondary to thermal effects of food which are small and account for no greater than 10% of the caloric value of ingested foods. Third is a metabolic requirement to meet the energy needed for physical activity. This energy depends upon the degree of activity and is the only part of energy expenditure amenable to significant manipulation. In the early 1960's there appeared an article that stated exercise was ineffective in increasing energy output because it required an extreme amount of activity to burn up calories for significant weight loss. Since that time several studies have demonstrated that an exercise program can be helpful for some patients and, in fact, was accompanied by a reduction in food intake. Not only is there a decrease in food intake but there also can result a decrease in body fat.[7] Charts noting exercise equivalents are available and are helpful in answering patients' questions. Although there is considerable reluctance on the part of the patient to exercise, particularly in the obese, if he is able to achieve effective levels of exercise, he will lose more weight. A study by Gwinup in California[9] examined the influence of exercise alone on the body weight of obese men and women on an unrestricted diet. Weight loss was slower than if there were no dietary restriction. Walking was the exercise best tolerated and weight loss correlated well with the time spent exercising. It appears that in some obese individuals exercise alone can produce weight loss.

The approach to physical fitness as it relates to obesity is one of assessment of basic health, followed by an estimate of obesity and then a therapeutic approach utilizing individualized programs of dietary restriction and graded exercise.

Diabetes Mellitus and Exercise

Control of blood glucose in patients with diabetes mellitus involves a balance of caloric intake (food-diet), caloric expenditure (physical activity) and adequate amounts of insulin which are necessary for effective energy utilization. These three components must be monitored and balanced. Approximately 85% of the patients with diabetes mellitus are those with Type II (maturity-onset, non-ketotic). The remaining 12 - 15% have Type I (juvenile-onset, ketotic, insulin-requiring) or have a secondary form of diabetes mellitus. Diet therapy is the cornerstone of diabetic therapy in both Type I and II diabetes mellitus. Control of the Type II diabetic may be achieved by diet and exercise. However, the effect of exercise in the insulin dependent diabetic may not be as clear-cut.

As discussed earlier, the physiologic response to physical exercise is a complex process involving circulatory, metabolic and hormonal influences. The effects of physical training, regularly performed and of sufficient vigor, can result in an increase in maximal oxygen uptake, a marked decrease in basal and glucose stimulated plasma insulin levels and an increase in insulin sensitivity in both people with diabetes mellitus and the nondiabetic. Physical training also has been shown to decrease serum triglyceride levels, increase maximal aerobic power and normalize work capacity. [6, 10]

Almost 60 years ago Allen observed that if blood glucose were greater than 300 mg%, exercise aggravated diabetes mellitus, but for blood glucoses under 300mg%, the diabetic state improved with exercise.[11] More recent studies have confirmed these earlier observations, that is, in poorly controlled insulin deficient diabetes, exercise can lead to deterioration of the diabetic state. This is evidenced by hyperglycemia, enhanced lipolysis, and increased ketogenesis.[6] Hyperglycemia is a result of increased hepatic glucose output without increase in utilization. There is an increased lipolysis and ketogenesis which is not balanced by increased free fatty acid consumption during exercise and these changes are exacerbated by increases in catecholamines, glucagon, cortisol, and growth hormones. It appears that there is a certain functional basal insulin level necessary for physiologic glucose production and utilization during exercise.

In addition to the potential problems of exercise in

the poorly controlled, insulin-dependent person with diabetes melitus, exercise can affect insulin mobilization from subcutaneous tissue. Several groups have reported increased insulin mobilization from the injection site when this body part is exercised.[12,13] This apparently results from a variance in insulin absorption into capillaries and lymphatic channels secondary to alterations of interstitial pressure as a result of contraction of underlying muscle. This effects hyperinsulinemia causing a disproportionate increase in muscle glucose utilization with a decrease in hepatic glucose output and a propensity to hypoglycemia. As reviewed by Skyler,[10] the clinical implications of exercise in diabetic patients are those substrate utilization characterized by increased energy expenditure secondary to exercise and thus, a resultant substrate requirement. Food should be provided for extra activity with the knowledge that the requirement for additional "fuel" may persist following exercise. This is especially true in insulin-treated patients. Increased mobilization of insulin from injection sites and increased insulin sensitivity should be anticipated. Exercise in insulin-deficient diabetes should be reserved for those diabetics whose glucose control is such that blood glucose levels don't exceed 300 mg% and in whom ketosis is absent. Exercise cannot be used as a substitute for insulin to control hyperglycemia or avert ketoacidosis.

The effect of exercise on the microangiography of diabetes has been recently reviewed.[14] In a given individual, diabetic vascular disease may have a pertinent influence upon the use of exercise and should be considered when advising patients with diabetes mellitus.

At present, knowledge concerning the effects of exercise are still being gathered and especially the relationship of exercise to diabetes mellitus. As in obesity, the patient's use of exercise must be individualized for maximum benefit and to avoid complications. With the exceptions noted above, regular physical activity with resultant improvement in physical fitness is to be encouraged.

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Corpulence, Indolence and Diabetes

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Obesity and Diabetes

"But in our age given to good fellowship and the guzzling down chiefly of unalloyed wine, we meet with examples and instances enough, I may say daily, of this disease."[1]

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Obesity is the major determinant of most diabetes occurring in adults.[2] This fact is generally appreciated, but the magnitude of the influence of body weight on the expression of diabetes in a society and the social cost of this problem are inadequately recognized. The National Diabetes Commission[3] estimated an annual cost of 5.3 billion dollars (in 1975) from diabetes; some 90% of this cost can be attributed to nutritionally induced diabetes.

As early as the 6th century, Hindu physicians attributed diabetes to dietary indiscretion.[2] Marked reductions in diabetes mortality rates have been recorded in several wars and many countries with nutritional deprivation,[4 6] even of relatively mild proportions.[7] Population studies have emphasized that prevalence of diabetes correlates with overweight in many cultures, races and areas of the world. Five to 9-fold differences in diabetes rates occur between lean and fat people of the same race, country and culture.[8]

Not only is blatant obesity a risk factor but relative fatness can affect susceptibility to develop diabetes. Joslin[9] was the first to record that diabetes was more common in average weight than in thin people. In one population study in the U.S., diabetes death rates could be correlated best with subcutaneous fat thickness estimated by photofluorography.[10] West's monumental 10 country study showed a linear relationship between diabetes prevalence and mean percent standard weight for each country (r=.89).[8] Helsinki policemen only 10% overweight had a 4-fold greater 5 year incidence of diabetes than normal weight co-workers.[11] Among nearly four thousand 40-50-year-old Norwegian men followed for 10 years, 12% of the very fat developed diabetes, but only 1% of normal weight and none of those leaner than normal did.[12]

In 1937, the Metropolitan Life Insurance Company[13] reported that death from diabetes was 8 times more frequent in those 24% or more overweight compared to those of normal weight and 13 times as frequent as in the underweight. Unlike the situation in underdeveloped countries, diabetes is more frequent among the poor in the U.S., because of higher obesity rates with poverty.

Obesity explains the sex difference in diabetes prevalence; the sex ratio can be corrected by matching for adiposity. Much of the age-related deterioration in glucose tolerance also appears due to increasing fatness and duration of overweight with age. In populations that remain lean or actually lose weight with aging, the age-related increase in diabetes incidence is blunted or absent.[2]

Duration of obesity is an important factor in the effect of weight on the appearance of diabetes, and this variable was considered in Joslin's landmark study.[9] In children who are obese, duration appears more important than degree of obesity in the expression of impaired glucose tolerance.[14]

Genetic forms of obesity and diabetes exist in laboratory animals, although, in some, diabetes can be prevented by dietary manipulation.[15 16] Certain American Indian tribes, including the Florida Seminole,[17] have rates of diabetes approaching 50% in the adult (over 35) population. Is this genetic diabetes with concomitant obesity or diabetes resulting from nutritional surfeit in a genetically susceptible host? Among high frequency populations, the association of diabetes expression with fatness is uniform.[2] Kobberling[18] has looked at the relative importance of overweight and heredity in non-insulin dependent diabetes by comparing rates of diabetes in siblings of mildly, moderately and severely obese probands (calculated as the product of percent overweight times duration in years). There is a 4-fold greater diabetes frequency in mildly than in severely overweight probands' sibs, indicating that the fatter the proband, the less genetic predisposition necessary to express diabetes. These observations fit well with current views of adult diabetes as multifactorial, with additive genetic and environmental components.

Attempts to implicate specific nutrients in diabetes causation have not been convincing. The most frequently accused substance is sucrose,[19] but neither experimental nor epidemiologic data that exclude the variable of total caloric intake support this hypothesis.[2]

Physical Fitness and Diabetes

"Amongst Zeminders and Talookdars who consider it a pride and honor to lead an indolent life, diabetes is a common complaint."[20]

Diabetes is rare in populations expending large amounts of energy in their daily lives. Joslin[21] correlated diabetes rates to electrical consumption within and between countries. Dissecting out the variables of energy expenditure and physical fitness from changes in food intake related to industrialization and urbanization is difficult. The high rates of diabetes among Sumo wrestlers of Japan[23] would suggest that physical fitness is protective only when associated with leanness. However, the conditioning of these individuals may be quite different than the continuous activity of the farmer or hunter.

The influence of physical fitness on diabetes rates is likely the result of the decrease in relative fatness for weight and the control of overweight by high energy expenditure.

How Corpulence/Indolence Induce Diabetes

Diabetes occurs as the result of inadequate insulin effect. Obese persons and inactive persons are hyperinsulinemic relative to the lean and physically active.[24] This hyperinsulinemia of the obese is due to fatness, not body weight. Although basal (fasting) insulin levels are high in obesity, insulin response to glucose is normal if expressed as a percentage of basal concentration, rather than in absolute levels.[22] The obese with diabetes have diminished responses by this criterion and their relative hypoinsulinemia is progressive as glycemia increases.[25]

The cause of excessive basal secretion of insulin in obesity is not known. Insensitivity of muscle to insulin has been shown in forearm infusion studies of obese persons,[26] and a number of investigators have suggested that there is diminished cell receptor binding of insulin in the obese.[27] The latter phenomenon, however, appears secondary to the hyperinsulinemia, rather than causal.

In fat people who lose weight insulin levels normalize, indicating that the obesity is the cause of, not the result of, the elevated insulin levels.[2]

Just as fatness relative to "normal" is associated with hyperinsulinemia, leaner than normal persons have low levels of insulin and heightened receptor binding. Physical training without weight loss in non-obese individuals resulted in greater sensitivity to infused insulin as measured by glucose intake, as well as increased binding to receptors on circulating monocytes.[24] Acutely, exercise lowers insulin levels in both obese and lean men, but most dramatically in the obese.[28]

In obese persons who already have glucose intolerance, the effects of conditioning alone, without important weight loss, may be limited. During an 8 week training program in 5 massively obese men with glucose intolerance, Bjorntorp[29] achieved a 5-10% increase in VO_{2max} without improving oral or IV glucose tolerance; fasting and IV-GTT insulin levels were diminished, but oral GTT insulin responses were not. In another study, 6 moderately obese and poorly conditioned men had a 15% increase in VO_{2max} after 14-38 weeks of training; IV glucose tolerance improved, but oral glucose tolerance and insulin secretion were unchanged. There were no appreciable weight changes.[30] In contrast to the lack of effect of conditioning alone on insulin response in the obese with diabetes, Saltin et al.[31] found that in normal weight patients with non-insulin dependent diabetes, after 6 months of training that increased VO_{2max} from 2.2 to 2.75 L/min, insulin responses to oral glucose were lowered while glucose tolerance improved.

What prescription emerges from these epidemiologic, clinical and experimental observations on the relationships between obesity, physical fitness and diabetes? The importance of diabetes prevention is emphasized by the large contribution of diabetes to cardiovascular-renal morbidity and mortality. As with alcoholism and smoking-related disease, the preventive solution is as difficult as it is obvious. The challenge to the physician is to stimulate and guide the necessary patient behavior, and he/she must do this in the clinic and in the community. The importance of this task was recognized by the Florida Legislature which recently established a statewide diabetes program consisting of Centers in the 3 Florida medical schools working with the Health Program Office of the Department of Health and Rehabilitative Services. This effort is focused on identifying and quantifying the diabetes problem in Florida and developing educational and service systems to aid health professionals and communities in diabetes management and control efforts.

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Exercise and Insulin Dependent Diabetes Mellitus

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Obesity is the major determinant of non insulin dependent diabetes mellitus and weight loss and physical conditioning can markedly improve glucose tolerance.[1] The increased insulin sensitivity associated with physical exercise should also be beneficial to patients with insulin dependent diabetes mellitus (IDDM). Physical exercise should be recommended in IDDM, but with qualifications and awareness of the unique metabolic problems of these patients.

Joslin recognized the importance of exercise in the therapy of IDDM in the triad prescription of exercise, diet, and insulin.[2] Insulin requirements have been shown to decrease with physical exercise.[3] Only recently, however, has exercise been considered as important a part of treatment as insulin and diet. This interest has been rekindled by the popularity of physical fitness and by attempts to simulate normal physiology in IDDM with new delivery systems.

More detailed information has become available on the quantitative contribution of blood glucose to energy needs with exercise and on the importance of hepatic glycogenolytic and gluconeogenic processes during muscular effort of varying intensity and duration. Current knowledge of exercise effects in diabetes was reviewed at a symposium sponsored by the Kroc Foundation and published in Diabetes.[4]

The body stores fuel for energy in the form of glycogen in the liver (80-90 gm) and muscle (300-400 gm) and triglycerides in adipose tissue. This represents only 8000 kJ of energy from carbohydrates, compared with the potential stores of 600,000 kJ as triglyceride. The liver however, is critical in maintaining blood glucose, storing or releasing the glucose as the situation demands. Muscle glycogen contributes little to the blood glucose pool since skeletal muscle lacks glucose-6-phosphatase.[5]

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Hormonal balance determines the direction and activity of glycogenolysis and gluconeogenesis in liver. After a meal insulin levels increase, glucose is stored as glycogen, and gluconeogenesis is inhibited. However, during exercise and starvation the reverse occurs. Insulin levels decrease and counter-regulatory hormones increase. The net effect is increased glucose production by the liver via glycogenolysis and gluconeogenesis. A similar effect of the hormonal balance on storage and breakdown of triglycerides occur in adipose tissue.[6]

During short bursts of intense exercise glucose (glycogen) is the primary metabolic fuel. As the duration of the exercise is prolonged, glucose continues to be important; however, free fatty acids (FFA) from the breakdown of triglycerides are increasingly used for fuel. After a physical conditioning period an adaptive phenomenon has been shown to occur in humans and animals. The activity of the enzyme systems responsible for the metabolism of FFA and ketone bodies is increased as a result of training in rats. The administration of acetoacetate to individuals after a short period of exercise will result in lower blood levels of acetoacetate in those individuals who are more physically fit. Thus, a well trained athlete can use these fuels more efficiently and spare the carbohydrate reserves. This is important since exhaustion can be defined biochemically as lack of available carbohydrate substrate for fuel.[7]

Exercising acutely increases binding of insulin to its specific receptor on circulating monocytes.[8] As the physical condition of the individual increases, the affinity of the insulin receptor increases.[9] Both effects would result in greater efficiency of insulin (lower insulin levels at similar glucose levels) in the well-trained individual.

An apparent paradox during exercise is that glucose uptake by muscle is increased despite lowered insulin levels. This may be partially explained by the acute increase of insulin receptor affinity and by the increased blood flow and delivery of glucose to the muscle during exercise.

After a period of exercise and consequently glycogen depletion in the muscle, glucose uptake by the skeletal muscle continues to be increased up to 24-72 hours in an attempt to replenish the glycogen. The available carbohydrate from a meal will even bypass the liver

to a greater degree in order to be stored preferentially in muscle. This has been called the "Monday effect".[5]

Patients with IDDM do not perform as well as their non-diabetic counterparts of similar age, sex, and body size.[10] The reason for this poor performance is unclear. Many factors might be involved: the lack of encouragement and opportunity for physical conditioning, frequent hypoglycemic episodes during physical exertion, worsening of hyperglycemia and ketonemia in some patients or lower stores of glycogen because of inadequate insulin therapy resulting in low stamina.

It is apparent that once or twice daily insulin injections in the patient with IDDM do not simulate the normal physiology of insulin secretion.[11] Thus the findings of lower glycogen levels in liver and muscle in patients with IDDM reflect inadequate glycogen synthesis due to suboptimal postprandial insulin levels.

Exogenous insulin administration in IDDM introduces variables that account for the effects of exercise on blood glucose level. Exercise increases absorption of the insulin from the subcutaneous site.[12] The increased levels of insulin consequently turn off glucose production by the liver and can result in hypoglycemia. The site of injection and the type of exercise is also important. The rapidity of absorption is more pronounced if the insulin is given in the leg and the exercise involves mainly the leg muscles. Injection in the abdomen affects the absorption least, while injection in the arm shows an intermediate increase of insulin levels with predominantly leg exercise.

Exercise has also been shown actually to increase the blood glucose level in patients with concentrations above 300 mg/dl and ketonemia. This phenomenon reflects low circulating levels of insulin with subsequent increased glucose production, increased breakdown of triglycerides and lack of glucose uptake by the muscle. Insulin has a "permisive" effect in that a minimum amount of insulin is required for glucose uptake to occur.[7]

Physical conditioning has been advocated in the treatment of ischemic heart disease.[13] One would assume as beneficial an effect of exercise on this large vessel disease in IDDM as is seen in non-IDDM or non-diabetic counterparts. However, the microangiopathy typical of IDDM and responsible for most premature mortality in these patients, complicates the issue. Counterregulatory hormones implicated in the development of microangiopathy are increased during exercise.[7]

Lactate and pyruvate levels rise far higher during exercise in patients with IDDM than in normals.[13] A possible basis for this increased production might be impaired oxygen delivery to the tissue because of increased thickening of the capillary basement membrane and higher affinity for oxygen of the glycosylated hemoglobin present in greater proportions in patients with IDDM.

Proteinuria occurs at a lower level of activity in patients with IDDM. The basis for this is thought to be an exercise mediated reduction in kidney blood flow. Exercise induced proteinuria has been advocated as a method to detect early nephropathy.[13]

Although these data suggest caution when recommending exercise to patients with significant microangiopathy, exercise should be considered without reservation in the absence of these complications. Physicians and health personnel who treat patients with IDDM need to teach the basic facts about exercise with comparable vigor to that usually devoted to diet and insulin therapy. Although the increased absorption of insulin during exercise is now generally recognized, few appreciate the benefits of continued uptake of glucose by the muscle for hours after the exercise is completed. We recommend a gradual increase in conditioning, dependent on the initial level of fitness. Dr. Kenneth Cooper has an excellent program outlined in his book "The New Aerobics".[14] One can not over-emphasize the need for starting slowly, for increasing the intensity gradually and for not overextending one's ability.

We have been impressed with the control of diabetes and psychological health of patients with IDDM who exercise regularly. The control of diabetes as measured by frequent hemoglobin A1C* determinations and blood glucose levels at home with Chemstrip®[15] is much better in patients who exercise regularly than in those who do not. Despite typically much higher insulin doses (1U/Kg body weight/day), the control of diabetes in these inactive patients is usually worse. An important aspect of physical exercise is the "good" feeling, the increased self awareness, self assertiveness, and self confidence that accompanies physical fitness. These benefits are enormously valuable to young people whose self images are damaged by this serious chronic disorder. This aspect of physical exercise is as important in the therapy of IDDM as the metabolic improvement. Because these patients feel good about themselves, they are more involved in their own management and more cooperative in the physician or diabetes team/patient effort to attain the best control possible.

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*Hemoglobin A1C is the glycosylated fraction, the proportion of which reflects average glycemia over the previous 2-6 weeks.

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An Ounce of Prevention

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Critics of our pluralistic health care system often state that if we expand "preventive medicine" programs diseases would either be prevented or discovered early enough to avoid costly complications. Such simplistic pronouncements provoke a multitude of responses which deserve occasional review if for no other reason than to keep discussion and debate within reasoned and reasonable levels.

For each of the last 18 years, the United States has had a decrease in the infant mortality rate. The exultation of the neonatologist is exceeded only by the joy of families who are grateful to their Creator for having a baby born at a time of such professional and scientific achievements.

Viewed in the light of pure economics, however, these frequently and seemingly miraculous accomplishments carry a high price; some neonatal centers report an average cost per baby saved in the range of $25,000 to $40,000. If dollars demand first priority, such efforts must be discredited as "uneconomical." This attitude was reflected in a report following a Consensus Development Conference on Antenatal Health sponsored by the National Institutes of Health. This report recommended a sharp cutback in electronic monitoring of babies during labor, i.e., controlling costs by controlling technology. To most of us, however, in a country where human life still carries no price tag, the question "how much does it cost?" is countered with a second question, "how much is it worth?"

One area of medical progress that can withstand critical cost-benefit scrutiny is immunization against the diseases of childhood. Untold millions of people the world over are alive and productive as a result of the scientific tools to prevent tetanus, diphtheria, whooping cough, measles, German measles, mumps and polio. These monumental successes, however, are minimally dependent upon the individual, but rather reflect advances in education and public health when integrated into the complex inter-relations involved in a nation's economic and social development.

In the absence of socio-economic progress and widespread education, singular efforts to prevent disease can be counter-productive. The recently announced worldwide eradication of smallpox has been met with justified acclaim, but in many underdeveloped countries, it will assure greater population growth and may actually undermine other health gains.

Inadequate food for a rapidly growing population, poor sanitation, contaminated food and water, poor housing, inadequate education and traditional cultural behavior and attitudes all contribute to the status of health and in the absence of economic and social development substantial achievement in health will rarely be accomplished. Except for some isolated and large city slum areas of the United States, these problems of

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developing countries are rarely met because of our nationwide progress in social and economic development and a highly advanced system of public health.

Our problems today involve not just bacteria and parasites and infectious and contagious disease, but a new list of causes of morbidity and mortality which can be attributed to the lifestyles of an affluent society.

Many people are enveloped in a false sense of security with the notion that if and when they suffer from their own self-indulgence, "modern medicine" and its miracles will get them out of trouble. They tend to abdicate responsibility for their own health.

A recent report from the Surgeon General suggested that about one half of all American deaths in 1976 were due to unhealthy behavior. Twenty per cent were chargeable to the environment, 20% to human biologic factors and only 10% to "inadequacies in health care." The picture is clear, and we medical professionals must work with those whose efforts are directed toward avoiding accidents, minimizing disability and promoting good health habits.

Without question some progress has been achieved as reflected in public awareness of disease prevention and health education programs. Many Americans have their blood pressure checked regularly. Jogging, tennis and other sports are growing, and health spa attendance is increasing. Many are slowing down their consumption of alcohol, and others are trying with mixed success to quit smoking.

A major problem in changing lifestyles is that unhealthy activities rarely have any immediate effect on health; the payoff for good health habits may not become obvious for 20 or 30 years or more. As long as people feel well, they are not sufficiently concerned or motivated to change their ways.

But we might be optimistic about a recent Louis Harris survey which indicated that an increasing number of Americans admit they might live longer, and have more healthy lives if they could summon sufficient will power to change such health-defeating habits as eating too much, sipping alcohol too often, sitting around too much and puffing on cigarettes.

I am forced to conclude from such polls and surveys that as medical professionals we must assume an increasingly active role as educators and motivators to support those cultural forces designed to promote habits for better living. Science and technology alone are inadequate to deal with the ever more complex problems of health care involving environment, attitudes, lifestyles and enlightened cooperation. Public understanding and cooperation are fundamental to progress, and we would do well to encourage any and all who are working toward those objectives.

There are still many physicians who limit their activities and are reluctant to depart from the traditional, more authoritarian interaction between themselves and their patients. Public need, however, dictates recognition and support of the many positive contributions toward better health that are being made by health educators, nurses, nutritionists, psychologists, social workers and community volunteers. But the physician's privileged status carries the responsibility to play a leadership role in persuading people that though he is willing and able to help them in the event of accident or illness, the primary responsibility for good health rests with them.

Statistics and experience indicate that further improvement in the health of our people will be accomplished mainly through prevention rather than by treatment.

The political rhetoric of the day concentrates on cost. The quality of care is taken for granted and no longer does the spotlight focus on availability, but rather now the attack is led by statements it "costs too much." These attacks are usually political in nature and are accompanied by claims that more "preventive medicine" would save money. Such allegations are preposterous and should be labeled as such.

Who can argue that the early detection and proper management of juvenile diabetics will not add years to their lives, but in the process will also prolong the years of needed medication and professional supervision? Similarly, early detection and treatment of hypertension has already proven to be tremendously effective in preventing premature heart attacks and strokes and in providing additional useful and productive years. The effectiveness of these and other therapeutic approaches are already reported in statistics that show that life expectancy at birth has increased from 47 years in 1900 to 73 years now. Further statistics show that the percentage of "senior citizens" is steadily rising, but by being able to live out our "three score and ten" we increase the infirmities and disabilities which accompany and require treatment during the later years of life's decline.

The automobile industry is a bellwether for the nation's economy, and when its costs go up, so do its prices; yet, there are no political outcries about cost escalations in this area. Many of our people have spent more money on the purchase, maintenance and operation of one automobile than they have spent on their health care in their entire lifetime!

The housing industry is another important segment of our economy; when it is healthy, it reflects more jobs and incomes both directly and indirectly. These and other industries are pointed to as positive evidence of a vibrant economy with ever widening employment for people to provide for themselves and their families and to pay, through taxes, for the running of their Government.

Why, then, should we not demand that the "health care industry" be treated fairly and in similar fashion? Its contributions are not limited to replacing the burden of disease with the costs of care. Already it is the second largest employer in the nation and stands second in its contribution of goods and services to the gross national product. Its benefits for American life and prosperity go far beyond the prevention and treatment of disease. It represents a large part of the nation's educational system. It is a source for the constructive employment in the building and maintenance of schools and hospitals. It also requires the employment of high income supporting skills to design, build and operate the sophisticated technological tools of today's medical establishment.

In a nation which recognizes and approves the principle that a "laborer is worthy of his hire," most physicians have reason to resent attacks on their incomes when those incomes, after years of preparation and demanding lifelong education and study rarely exceed that which they would have received in pre-tax dollars from an average of 60 to 65 hours of weekly work as a skilled carpenter, plumber or electrician.

In the last analysis, the public are our patients, and it is our individual patients who contribute to the makeup of the public. To the extent that we tell our story honestly, simply and understandably, we will be heard and supported, and to the extent that we persevere in our efforts to inform, to educate, to persuade and to cajole our patients to join us as partners in our work of achieving true "preventive medicine" here too we have reason for optimism.

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Heat and Physical Activity

Arthur J. Pearl M.D.

Abstract: Heat disorders in the athlete can be prevented by an adequate physical and history, a period of acclimatization including frequent rest periods in a shaded environment, adequate fluid and salt replacement before, during and after an exercise period, weighing the athlete daily and watching for any excessive weight loss in a given 24 hour period, restricting strenuous physical activities if the heat and humidity are high, wearing white, loose fitting clothing and proper physical conditioning. Heat disorders can be prevented by early recognition and early treatment. Heat stroke, an often fatal condition, is a medical emergency and prompt treatment is mandatory.

Heat illness is a result of the imbalance between heat production by the human body and heat loss as affected by any given environment. The body generates heat by muscle and metabolic activities. Seventy percent of the body heat is dissipated by radiation, conduction and convection. Thirty percent is by evaporation from the respiratory tract and skin. When the environmental temperature rises above 87 degrees Farenheit, then 70 percent of the heat dissipation capacity is lost and the body depends primarily on the evaporation mechanism for heat loss. As the humidity rises the ability to lose body heat by evaporation also diminishes.[2,4] The hypothalmus regulates heat dissipation through cutaneous vasodilatation and sweating and provides a homeostatic mechanism for water balance. With significant increase in body temperature the hypothalmus regulatory mechanism is disrupted.[1,2] As the body temperature rises the heart pumps greater volumes of blood in order to cool the body and cardiovascular collapse can be related to this overload.[4] The fluid loss by the body through perspiration is derived from the interstitial fluid.

During heat stress the kidneys resorb water in the renal tubules. Salt is conserved only after a period of acclimatization. A potassium deficit may arise because of the sodium conserving process. Fluid is lost much more rapidly than it can be taken in during exercise and should be replaced during and after physical activities.[2] The adaptive process of acclimatization to heat stress

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requires work in a warm environment and salt and water replacement. With acclimatization an athlete can function at a higher achievement level in an environment of increased heat. This acclimatization process should occur gradually allowing increased sweat production with diminished salt content beginning at a lower skin temperature. As an athlete becomes acclimatized his cardiac output and blood volume are increased.[5] Initially the blood production is increased to improve cooling but usually returns to near normal after two weeks of work in warm environments.

The prevention of heat injury requires a complete history and physical examination particularly looking for a history of previous heat illness, diminished ability to perspire or peripheral vascular disease. Athletes who are at a greater risk to heat injury are those who are unaccustomed to working in heat, overweight, large individuals or those athletes who have been ill particularly with a fever, vomiting or diarrhea.

The level of physical activity should also be determined and altered by measuring the temperature and humidity on the practice or playing field with the use of a sling psychrometer. This measures the dry bulb and wet bulb temperature and the application of a safety index as outlined in Table 1 should be followed reducing activities in the hot, humid environment.[2] The athlete should be weighed daily before and after each practice and any weight loss should be recorded. Any athlete losing two to five pounds in a given 24 hours should be watched carefully. Any athlete who loses 10 pounds within a 24 hour period should be considered a risk candidate for heat illness.[6] If an athlete has vomiting and diarrhea he should avoid practice. The clothing should be light, loose and white. Unnecessary clothing and equipment should be eliminated particularly during the hot and humid conditions. Physical fitness tests measuring endurance at the beginning of hot weather training will indicate the athlete's physical ability to perform at a given level. Those athletes in poor physical condition are candidates for heat illness and should be worked in selective drills until they are ready to participate.

The acclimatization process allows the athlete to adapt to working in heat with an improvement in performance and diminution of discomfort as they achieve this physiologic level. The acclimatization process requires work in heat and also requires salt and water replacement. There is no basis for denying water to the athlete to make him "tougher." During the initial few days of acclimatization frequent rest intervals and electrolyte fluid replacement should be the keynote. There should be a 10 minute rest period every 30 minutes of activity giving at least 10 ounces of saline each rest period. Begin with cold water and 4 tsp. of salt per gallon, which may be diminished the following week to three tsp. per gallon, then the 3rd week to two tsp. per gallon until cool weather arrives. With a normal acclimatization and proper food intake no further salt replacement is necessary but only water. During the acclimatization period rest in cool shaded areas that have good air movement is essential as is the utilization of light, white, loose fitting clothes. Two practices of two hours daily are most beneficial. Acclimatization should be in four to seven days up to 12 to 14 days.

Heat illnesses or circulatory instability warn of electrolyte imbalance and predispose the athlete to heat stroke or hyperpyrexia. Circulatory instability is characterized by syncope or fainting, light headedness, dizziness associated with postural changes, nausea and weakness. Patients have a diminished blood pressure with an elevated pulse rate and recovery is usually rapid if the athlete will spend a few minutes in a reclining position. Heat edema results in swelling of the feet and ankles during an exposure to heat probably secondary to venous pooling. With loss of water and electrolytes from sweat the rectal temperature increases as does the pulse and respirations, the skin will become inelastic and the patient may have paresthesia, listlessness, hyperventilation, hysteria giddiness and uncoordination. This may

Table I

Use of the Wet Bulb Globe Temperature Instrument
To Determine Environmental Conditions
For Football

1. Application of Safety Index
Each component of the instrument has been given a factor of importance, as relates to heat stress, in arriving at a safety index or scale. The index reading is obtained by adding:

0.1 X the dry bulb temperature
+ 0.2 X the black bulb temperature
+ 0.7 X the wet bulb temperature

WGBI Index

II. Adjust Activity Accordingly During Acclimatization Period

WBGI Index	From 82 to 85 degrees	light exercise
	From 85 to 88 degrees	no exercise but may give instructions in the shade
	Above 88 degrees	all activity discontinued

III. After Acclimatization (10 days)

WBGI Index	Above 85 degrees	strenuous exercise is stopped
	Above 88 degrees	all exercise is stopped

Iv. A. When the wet bulb reading is within three degrees of the dry bulb reading, all activity should be suspended.
B. When the wet bulb reading is from 3 to 5 degrees below the dry bulb—helmets, sweat shirts, and shoulder pads should be discarded and activity slowed down.
A & B. Apply to both the acclimatized period and afterwards.

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lead to cyanosis, hypotension, urinary failure, heat stroke and death. Although water and salt depletion often coexist, cramps from heat stress may be caused by water intoxication.

The intracellular fluid has a dilution of the sodium chloride content which is compounded by salt loss in sweat. A normal saline solution can prevent and treat this entity. Enteric salt tablets do not have a role to play in the treatment or prevention of electrolyte depletion. Heat stroke begins by a primary failure of the production of sweat, and circulatory collapse leading to cardiac failure.[4,7] The patient has coma, delirium, convulsions, disorientation, incontinence, the skin is hot and dry, there is a failure of sweating, temperature will be high, and there will be cyanosis. When heat stroke is suspected the athlete should be stripped, fanned, kept moist and the body temperature should be lowered to 102 degrees in less than an hour. A tracheostomy may be necessary to maintain a good airway. Supportive care in the form of intravenous saline drip should be instituted. The patient should be monitored for the possibility of cardiac failure, pulmonary edema and arrythmias.[4] Heat exhaustion is treated by removing the athlete to a cool environment, fluid and salt replacement over a two to three day period and then reacclimatization. With heat exhaustion of a salt depletion type the signs and symptoms are fatigue, weakness, headache, nausea, vomiting, loss of appetite, muscle cramps, diarrhea or fainting, urine output is normal but almost salt free, elevated BUN, low serum sodium and a diminished circulatory volume. The treatment is replacement of fluid and electrolytes under clinical and laboratory control in a cool place.

In summary, heat disorders in the athlete can be prevented by an adequate physical and history, a period of acclimatization including frequent rest periods in a shaded environment, adequate fluid and salt replacement before, during and after an exercise period, weighing the athlete daily and watching for any excessive weight loss in a given 24 hour period, restricting strenuous physical activities if the heat and humidity are high, wearing white, loose clothing and proper physical conditioning. Heat disorders can be prevented by early recognition and early treatment. Heat stroke, an often fatal condition, is a medical emergency and prompt treatment is mandatory.

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A History of Elderly Exercises

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The 20th century has seen an explosion in the number of advocates of exercise. There are a multitude of types, degrees and methods proclaimed in the lay and medical literature. This signifies the incomplete understanding, testing and agreement on exercise today. Focusing on the elderly exercises creates an even greater diversity of judgement. Most concur that some exercise has a salubrious outcome in all ages. Such conformity has not been observed in the past. Therefore, this piece will not attempt to prescribe, but only to document how exercise was suggested to be done in previous writings of note.

The Yellow, Hung-Ti, has been given credit by some to have written an extensive treatise on medicine.[1] I shall not belabor the argument as to when the book was actually written or by whom. Exercise was used medically in the treatment of diseases to promote well-being. Breathing movements, rotation of all parts of the body, massaging the abdomen and pulmonary toilet movements such as percussing the chest were advocated.

Later, shadow-boxing gymnastics evolved. This was just an exaggeration of movements of all segments of the body and proportedly began during the Sung Dynasty. Kung Fu, so popularized by our 20th-century TV, might well be the oldest recorded postures that could be ascribed to learning exercises.

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Asklepios, the god of medicine and son of Apollo, had many temples of medicine dedicated to him in Greece. These forerunners of hospitals promoted exercises in all ages. They were intimately involved with war and athletic endeavors, hence the Olympian contests. As in modern times, the pendulum swung too far occasionally, and during the 4th century B.C., the treatise *Ars Gymnastica* was labeled as promoting too ardous exercises for all ages.

Hippocrates, our patron saint, advocated using in moderation, all moving parts of the body, for if left idle, they would become diseased and age quickly. The Greeks promoted exercise to preserve health.[2] Paraphrasing a translation of Socrates (470 B.C.), even in old age he learned to dance and play instruments and thought the time well-spent.[3]

The Greek physician, Asclepiades of Biphynia (124 B.C.), eulogized as the father of geriatrics, prescribed diet, massage, bathing, and exercise in moderation. Walking was strongly encouraged for patients with chronic diseases.[4]

The Greek word, aiora (balancing), and later changed by the Romans to gestation from the word for carry, consisted of therapy by transporting the patient by litter, horseback, boat or chair, causing various degrees of vibrations and shaking, thereby having beneficial effects on the physical and mental disturbances.[5] Various suspended couches, beds and benches were referred to as means of unstopping the pores and allowing removal of corpuscles.

Celsus, in his *De Medicina*, advocated exercise strongly pursuant to good health. In one of the speeches of Cicero, *De Senectute* (44 A.D.), he talked of a man even in old age preserving vigor by exercise and self-control.[6] He describes one man who continued to till the soil to his hundredth year. Playing ball was promoted for old as well as young. Other Roman writers extolled the virtues of many kinds of activities.

During the Middle Ages, there were few advocates of exercise for anything. Maimonides, during the 13th century, did allude to the sorry state of a lack of exercise in his community. During the 15th century, the Latin and Greek literature was rediscovered. There were numerous referrals to physical exercise for all ages. The first book on geriatrics appeared in 1489, *Gerentocomia.*[7]

The Book of Bodily Exercise by Christobal Mendez, 1553,[8] deemed walking and playing ball particularly useful to preserve health. He writes of ages being divided into segments. The fifth age, old age, is over 40. He suggested that they ride horses and walk for a spell. He also recognized the advantage of continuing more strenuous exercise if one had previously engaged in them. For those in the sixth age, temperance in all activities was promulgated.

Herman L. Kamenetz, in his excellent chapter in the *Guide to Fitness After Fifty*, by Raymond Harris, M.D., and Lawrence J. Frankel, M.D., calls attention to the book, *The Art of Gymnastics Among the Ancients*, as being the most important work for centuries following its publication in 1569. This was a compilation of many authors and recommended exercise for all ages. He describes a game involving throwing a ball which was particularly useful in strengthening the arms and legs of old men who could not engage in the more arduous games. Again, he stressed walking as the most important exercise even for the weak and sickly. Loud talking and breathing activities were recommended as had been long before in ancient China, India, and the Roman times.

The middle-aged person, particularly, needs a regular program because many latent diseases appear at this time, extolled Marsilius Cognatus in his book on gymnastics.[9]

Even some of the philosophers of the time sang loudly to preserve their lungs. Great interest in the physical and chemical aspects of exercise broadened the knowledge of the importance of purposeful activities.

Friedrich Hoffmann (1660-1742)[10] wrote many dissertations on longevity. He considered both mental and physical regular exercises as the most important deterrent to old age and infirmities. He deduced that a peasant worked hard thrashing, cutting, and harvesting, and thereby incurred good health and strength.

In the 18th century, Sir John Floyer, a physician in England, published the first English treatise on geriatrics.[11] Walking still was the most recommended for the aged. A significant book by Tissot appeared in 1780. His approach, while not new, was more precisely stated that exercise for the elderly should be a continuance of those that they had been doing and enjoyed. A formidable work on exercise appeared in 1896, written by the German physician, Christoph Wilhelm Huferland. He described different lifestyles that would shorten or lengthen age. Per Henrik Ling is credited with creating medical exercise and gymnastics and Swedish massage in the early 19th century. The other Scandanavian countries as well as Germany followed suit with their versions of proper exercises for the various ages. In America, during the mid-19th century, George Taylor published books extolling the virtues of the Swedish exercises and himself invented several devices that are still being copied today. It was during this time that spas developed, combining hydrotherapy with exercises.

There were many authors during this period writing of the efficacy of exercise. The usefulness in actual treatment was not resolved.

Since the present century is not at an end, I will not present ideas and concepts that are not freely available to all.

In summary, the physicians and thinkers of old generally advocated some type of exercise as being beneficial to the elderly person. This just recalls the old adage, "There is nothing new."

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Some Tried and True Rules of the Road for Joggers

George Sheehan, M.D.

1) Keep a record of your morning pulse. Lie in bed for a few minutes after you awaken and then take your pulse. As your training progresses it will gradually become slower and after three months or so plateau out. From then on, should you have a rate ten or more beats higher you have not recovered from your previous day's runs, races or stresses. Take the day or more off until the pulse returns to normal.

2) Weigh regularly. Initially you will not lose much weight. What you lose in fat you will put on in muscle. Running consumes 100 calories a mile and there are 3,500 calories to a pound so you can see weight loss will be slow unless you do heavy mileage.

3) Do your exercises daily. The more you run the more muscle imbalance occurs. The calf, hamstrings (back thigh) and low back muscles become short, tight and inflexible. They have to be stretched. On the other hand the shins, the quads (front thigh), and the belly muscles become relatively weak. They must be strengthened. Learn the Magic Six: Three strengthening exercises, three stretching exercises.

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4) Eat to run. Eat a good high-protein breakfast, then have a light lunch. Run on an empty stomach at least two, preferably three hours after your last meal. Save the carbohydrates for the meal after the run to replenish muscle sugar.

5) Drink plenty of fluids. Take sugar-free drinks up to 15 minutes before running. Then take 12-16 ounces of easily tolerated juices, half strength "ades," tea with honey or sugar, defizzed Coke, etc. before setting out. In winter that should be all you need.

6) Run on an empty colon. Running causes increased peristalsis, cramps and even diarrhea. Having a bowel movement before running and particularly before racing prevents these abdominal symptoms.

7) Wear the right clothes. In winter this means a base of thermal underwear followed by several layers of cotton or wool shirts at least one a turtle neck. Wear a ski mask and mittens. Use nylon if necessary to protect against wind and wet. In summer the main enemy is radiant heat. Remember to wear white clothes and use some kind of head covering.

8) Find your shoes and stick to them. Heavy people do better in tennis shoes and basketball sneakers. High arch feet do better with narrow heels. Morton's Foot (short big toe, long second toe) may need an arch support in the shoe. If a shoe works, train in it, race in it, and wear it to work.

9) The fitness equation is 30 minutes at a comfortable pace four times a week. Your body

should be able to tell you that "comfortable" pace. If in doubt use the "talk test." Run at a speed at which you could carry on a conversation with a companion.

10) Run economically. Do not bounce or overstride. You should lengthen your stride by pushing off, not by reaching out. Do not let your foot get ahead of your knee. This means your knee will be slighty bent at footstrike. Run from the hips down with the upper body straight up and used only for balance. Relax.

11) Belly breathe. This is not easy and must be practiced and consciously done just prior to a run or a race. Take air into your belly and exhale against a slight resistance either through pursed lips or by a grunt or a groan. This uses the diaphragm correctly and prevents the "stitch."

12) Wait for your second wind. It takes about six to ten minutes and one degree in body temperature to shunt the blood to the working muscles. When that happens you will experience a light warm sweat and know what the "second wind" means. You must run quite slowly until this occurs. Then you can dial yourself to "comfortable," put yourself on automatic pilot, and enjoy.

13) Run against traffic. Two heads are better than one in preventing an accident. Turn your back on a driver and you are giving up control of your life. At night wear some reflective material or carry a small flashlight.

14) Give dogs their territory. Cross to the other side of the road and pick up some object you can brandish at them. Never try to outrun a dog. Face the dog and keep talking until it appears safe to go on.

15) Learn to read your body. Be aware of signs of overtraining. If the second wind brings a cold clammy sweat, head for home. Establish a DEW line that alerts you to impending trouble. Loss of zest, high morning pulse, lightheadedness on standing, scratchy throat, swollen glands, insomnia, palpitation, are some of the frequent harbingers of trouble.

16) Do not run with a cold. A cold means you are overtrained. You have already run too much. Wait at least three days, preferably longer. Take a nap the hour you would usually spend running.

17) Do not cheat on your sleep. Add an extra hour when in heavy training. Also arrange for at least one or two naps a week and take a long one after your weekend run.

18) When injured find a substitute activity to maintain fitness. Swim, cycle or walk for the same time and frequency that you would normally jog.

19) Most injuries result with a change in your training. A change in shoes, an increase in mileage (25 miles per week is the dividing line, at 50 miles per week the injury rate is doubled), hill or speed work, or a change in surface. Almost always there is some associated weakness of the foot, muscle strength/flexibility imbalance, or one leg shorter than the other. Use of heel lifts, arch supports, modification of shoes and corrective exercises may be necessary before you are able to return to painfree running.

20) Training is a practical application of Hans Selye's General Adaptation Syndrome. Stress is applied, the organism reacts, a suitable time is given to reestablish equilibrium. Then stress is applied again. Each of us can stand different loads and need different amounts of time to adapt. You are an experiment-of-one. Establish your own schedule, do not follow anyone else's. Listen to your body. Train, don't strain.

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Muscle Biopsy Research

Application of Fiber Composition to Swimming

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Much has been said about the muscle biopsy procedure and its application to sports. As a result, there are some misconceptions that need to be viewed in their proper perspective. The purpose of this article will be to (1) clarify some technical aspects of the biopsy procedure, (2) show the practical uses to be made of this

technique, (3) suggest some noninvasive ways of approximating one's muscle fiber composition without doing a biopsy, and (4) illustrate some of the adaptations which occur in muscle as a result of aerobic and anaerobic training.

We have a policy in our laboratory regarding the biopsy procedure. If you have not had a biopsy performed, you are not permitted to watch someone else being biopsied. The reasoning behind this policy is that the biopsy method looks more painful than it feels. The needle is relatively large (roughly half the diameter of a ballpoint pen) and is inserted 1.5-2.0 inches into the belly of the muscle through a small incision in the skin. Even the description sounds painful. There is, however, little sensation for the subject. A small amount of anesthetic (1-1.5ml of Xylocaine) is injected into the skin and surface of the muscle. Provided the muscle is kept relaxed, the only sensation experienced by the subject is a feeling of pressure, with little or no discomfort at the time the biopsy specimen is cut.

In the past four years we have performed more than 2000 biopsies from calf, thigh, shoulder and upper arm muscles. Aside from some typical muscle soreness the following day or two, the only complication we have experienced has been three cases of excessive bleeding under the skin, which can make the area very tender. We have never had a skin or muscle infection and all athletes have been able to continue their training without interruption.

Enough about the procedure. Now let's answer an important question! What can we learn from the biopsy specimen that can make a swimmer perform better? Our immediate answer would be "Nothing." This method should not be used on every swimmer. We view this procedure as a research tool that can be used for such things as detailing the best methods of training to improve performance. From the small piece of tissue obtained with the biopsy needle we can look at the composition of slow and fast twitch fibers, describe which fibers are being used during swimming, examine the adaptations in muscle with strength and endurance training, and describe the diets best suited for optimal muscle performance.

Composition of the Swimmer's Muscle—Jim Counsilman did a good job of explaining the characteristics of muscle fibers in his earlier article "The Importance of Speed in Exercise," **(Scholastic Coach**, 46:94-99, 1976). Let me take some time to update that information. First, human muscle fibers can be classified as slow twitch (aerobic fibers), fast twitch type A (anaerobic, moderate aerobic) and fast twitch type B fibers (anaerobic, poor aerobic). On the average, most untrained people have 50% of their mixed-muscles (e.g. gastrocnemius) composed of the slow twitch (ST) fibers, 25% are fast twitch type A (FT_a) and 25% fast twitch type B (FT_b). It has been well documented, however, that swimmers and other trained endurance athletes often show some deviations from these percentages. It has been noted in track athletes, that successful sprinters have an abundance of FT fibers, while world class distance runners have mostly ST fibers. Frank Shorter (1972 Olympic Marathon Champion), for example, has 80% of his gastrocnemius (calf) muscle composed of ST fibers. Most world class sprinters, on the other hand, have less than 20% of this muscle composed of ST fiber. Sprint and distance swimmers exhibit similar distributions, but there is much greater overlap.

Since most swimming events (50-400 meters) can be classified as sprint and middle distance, it is not surprising to find that the majority of the swimmers we have studied have fiber compositions in the deltoid muscle that range from 30 to 68% ST. Obviously, with such a wide variation, there seems to be little chance that we could tell a swimmer what distance would be best for him/her on the basis of fiber composition. We are inclined to feel, however, that even in these swimmers, their ability to maintain high speeds at longer distances may be related to the %ST fiber in their muscles. Since FT fibers are poor users of oxygen and perform poorly in endurance events, those swimmers who are endowed with a high percentage of these fibers may be less well suited for the 200, 400 and 1500 meter events. I am sure we can all give examples of individuals who are great sprinters but fade badly at distances beyond 100 meters. Some "fall apart" at the 100 meter distance and prefer to limit their races to the 50. These same individuals seem to have a terrible time with interval workouts, and often need a personal lifeguard. In the few cases we have been able to study, these sprinters have more than 75% FT fibers. Since FT fibers are quickly fatiguable and highly anaerobic, there is some question that endurance training can make these individuals competitive in events longer than 100 meters.

Recruitment of Muscle Fibers—Human mixed muscle have ST and FT fibers scattered throughout. Surprisingly, however, the nervous system has the ability to selectively recruit given bundles of a particular fiber type (motor units) in an effort to perform the specific work of the muscle. One method of examining this selective recruitment of muscle fibers is to measure the amount of muscle sugar (glycogen) being used by each muscle fiber during different types of exercise. If the muscle fiber is heavily recruited, then the amount of glycogen burned will be great, while the glycogen content of the less active fibers will show only small decreases.

After a long, slow exercise bout, certain muscle fibers are empty of glycogen. On close examination we

have found that the depleted fibers are mostly ST, while the FT fibers seem to have plenty of glycogen. Sprint bouts of exercise, however, produce a different pattern of muscle glycogen depletion. After repeated 20-30 sec sprints, the FT fiber is depleted of glycogen, while the ST fibers have apparently been less active.

Thus, it appears that during slow endurance exercise the muscle fibers most heavily used are the ST, while the FT fibers are not called on until the intensity of exercise is quite high. These data indicate an important aspect of training: specificity. If the swimmer were to train using only long slow distance, then the major training gains would be limited to the ST fibers. Since during competition much of the muscular work must be performed by the FT fibers, it seems that such a training program would fail to prepare some of the muscle fibers (i.e., FT) for an optimal performance. Of course, the opposite would be true if training were limited to repeated sprints performed at race pace or faster. Ideally, training should include a greater proportion of aerobic work to enhance the endurance qualities of both ST and FT fibers, but at least twice per week, the swimmer must perform repeated sprints of 20-30 sec to achieve an acute overload on the FT fibers and to training the nervous system to recruit muscle fibers in a pattern that simulates the competitive situation.

We must, however, caution against the overuse of this emphasis on speed. Since very high intensity work places great demand on the energy stores, principally muscle glycogen, and may be emotionally stressful, excessive use of sprinting can lead to premature peaking and physical and psychological staleness.

What about strength training? What can swimmers gain from resistance exercise on land that will enhance performance? To answer this question we must first determine which fibers are used during maximal muscular contractions. During maximal isokinetic exercise we have observed that both the ST and FT fibers are being used. By dissecting out ST and FT fibers under a low power microscope we have been able to measure the actual quantity of glycogen used from these fibers. As can be seen in the following table, at slow speeds (60°/sec) of maximal muscular contraction both ST and FT fibers use about the same amount of glycogen. At high speeds, however, the FT fibers seem to be most heavily recruited. As a result, individuals with a predominance of FT fibers are capable of developing greater power at high speeds of muscle shortening. These findings support the concept that strength training should be performed at speeds similar to those used in swimming. In this way, strength gains will be more readily applied to the forces needed during compeition.

Table 1
Muscle glycogen utilization in slow twitch (ST) and fast twitch (FT) fibers during maximal isokinetic exercise at low (60°/sec) and high (300°/sec) velocities

Velocity	Fiber Type	Muscle Glycogen (mmol/kg dry tissue) Before	After	Amount Used
60°/sec	ST	574	289	-285
	FT	613	338	-275
300°/sec	ST	579	283	-296
	FT	634	268	-366*

*Denotes significant difference

Predicting Fiber Type—Obviously it takes a high degree of technology to assay for muscle fiber composition. When we combine this problem with the subjects' apprehension of the biopsy procedure, it becomes clear that not all swimmers can or should be biopsied. Nevertheless, many athletes and coaches want to have some indication of fiber composition. For that reason we have attempted to develop some tests that predict muscle fiber composition without the use of surgery.

In our preceding discussion we have pointed out two characteristics of FT fibers that can be tested, and do reflect their proportions in muscle. The first of these FT qualities is their greater ability to develop tension at high velocities. Utilizing a Cybex II unit it is possible to measure the peak power capabilities of an isolated muscle group at different velocities. The speed of contraction is increased as the swimmers with mostly FT fibers continue to develop power. The individuals with a predominance of ST fibers are unable to increase their power output at the high speeds and are easily identified.

Another noninvasive test for fiber type examines the greater fatiguability of the FT fibers. Using an isokinetic bicycle ergometer we can ask the subject to cycle at maximal effort for 30 to 45 sec and examine the rate of fatigue. Those individuals with a predominance of ST fibers fatigue much more slowly than do persons with predominantly FT fibers. The correlations for these two tests show that they are modestly good predictors of fiber composition (velocity/power, $r = 0.71$; fatigue rate, $r = 0.73$). We are currently collecting data which will enable us to combine the results of these two tests and provide an equation that will allow us to predict muscle fiber composition with a greater degree of accuracy.

We would be remiss if we did not address the issue of predicting fiber composition from a vertical jump test. The theoretical basis for this concept is that sprinters have a higher percentage of FT fiber and are generally good jumpers. Thus, it seems logical that the ability to jump would reflect a high percentage of FT fibers in the

leg muscles. Unfortunately we have failed to find evidence to support this theory. When a large group of subjects (N = 49) were tested, we found the correlation was only 0.21 between vertical jump and the % FT fibers. The reason for such a low index of predictability may be that there are factors other than fiber type which contribute to the height of one's vertical jump. Training is one such factor. Endurance training (running), for example, has been shown to decrease one's vertical jump. It is also possible to have a high percentage of FT fibers, but have a small muscle mass and thus be relatively weak. Such an arrangement would lessen the likelihood of a high vertical jump. On this item I speak from a position of first hand experience. Aside from the tests of power and fatiguability mentioned earlier there appears to be no simple test to predict fiber type. We feel, however, that within the next few months we should be able to develop a swimming protocol that can be used for predicting % FT fibers in the arms of most swimmers with reasonable accuracy.

Changing Muscle Fiber Composition—In light of all this discussion of the importance of muscle fiber composition to swimming performance and specificity in training, the next logical question is "Can one's muscle fiber composition be changed by training." A couple of years ago we would have answered with an unequivocal "no." We now have evidence to show that our earlier concepts were somewhat in error. At the same time, however, we weren't wrong on all aspects of this question. One point still seems certain, will training not change ST fibers to FT or vice versa. Since fiber type is determined by the size and function of the neurons (nerves) that supply a muscle fiber, a change in fiber type would require a change in the type of neuron that innervates the muscle fiber. The only methods known to alter the contractile characteristics (slow or fast twitch) of a muscle are either surgical cross innervation (changing the neurological input to a muscle) or chronic electrical stimulation. Neither of these approaches are of any value in our efforts to optimize the swimmer's performance.

These points do not negate the fact that we may induce changes in the composition of muscle through strength and endurance training. Endurance training unquestionably causes some modifications in the subtypes of FT fibers. There is overwhelming evidence to show that the FT_b fiber becomes FT_a, while the % ST fibers remain unchanged. Most exercise physiologists are reluctant to speculate on the cause for this shift in FT_b to FT_a. We are inclined to think that it merely reflects the increased use of the FT fibers during endurance training. It is possible the fiber types do not change in function but merely respond differently to our technique of staining the fibers. That is, the FT_b fibers do become more oxidative (aerobic endurance) with swimming training and thus demonstrate the qualities of the FT_a fibers. Many highly trained swimmers possess no FT_b fibers in their upper body musculature.

Strength training causes a similar increase in % FT_a but only a small decrease in the FT_b fibers. This may be due to cell division in the FT_a population of fibers. There is convincing evidence to show that chronic tension overload on the muscle will induce a splitting of some muscle fibers (Gonyea, *et al. Acta physiol scand.* 1977. 99:105-109), which would in effect show a relative increase in that fiber type (FT_a) and a percentage decrease in the non-splitting fiber type. This appears to be the case, since the % FT_a fibers is markedly increased after strength training.

There is other evidence to support this concept of fiber splitting in human muscle. We recently biopsied a group of body builders and world class shot putters whose gastrocnemius muscles were at least 3 times larger than those of untrained men of similar stature. Upon microscopic examination we found that the cross sectional areas of their muscle fibers were no larger than those sedentary, untrained men. Since the total muscle mass of the gastrocnemius muscle was more than 300% greater than that of the untrained men, we can only conclude that years of strength training have produced an increase in the number of muscle fibers through cell division. In any event, it is now obvious that the contractile properties of muscles do in fact change with training, but the stimulus and nature of that change seems to differ with the swimmer's mode of training. It should also be realized that these changes are quite individual. Not all individuals can achieve the muscle mass changes of the body builder, not will all swimmers' muscle show the same modifications with endurance training.

Conclusion—Certainly we have not treated all the questions that have been asked about the muscle biopsy technique. If we have learned anything it is that this technique is a research tool that should be employed to direct our training of athletes and to assist in optimizing performance. It is not intended to be used for predicting potential success in sports, especially swimming. The use of such scientific tools should be to provide knowledge that will assist athletes in approaching the physical potential they have inherited.

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Weight Training - Benefit or Hazard?

Joseph C. Von Thron, M.D.

Weightlifting has become an integral part of the training program utilized by all coaches in nearly all sports; however, after having observed a number of fine athletes lose their dexterity by becoming "muscle bound," and concomitantly noting the pressure being placed on my own son, I decided to investigate this form of practice and preparation for athletes.

When plunging into my inquiry, I quickly realized there were no true authorities on the subject, either in medicine or in the athletic arena. Consequently, I have tried to glean my knowledge and information for preparing this paper by consulting the most successful coaches, athletes and team physicians representing the various sports one might observe in America.

As a matter of background the concept of weightlifting as a training method in sports more or less originated with Hank Stram when he was head coach of the Kansas City Chiefs. Through his efforts he developed a Super Bowl champion football team largely because, on a one on one basis, his players were far superior in physical strength to their opponents. The major contribution to his successful program came from extensive weightlifting training. Thus a trend began that has now filtered down even to the elementary school athlete. As a result an entirely new dimension is being added in terms of physical development in all sports, and it appears the large majority are finding that the added time spent in strength development has resulted in measurable rewards in increased athletic prowess.

Enthralled with the notion that perhaps my own son could gain an edge on his competitors, we (Dad and Son) began an intensive weightlifting program when he was in the sixth grade. It paid off; he soon became a dominating force in sports at the grade school level. Then the world collapsed. His high school coaches forced him into a weightlifting program designed, by whomever, to continue his benchpressing, squats, clean and jerks, etc., ad nauseum. As a high school varsity catcher, he could no longer regularly hit second base on the steal; as quarterback of the high school football team, his distance, velocity and accuracy diminished. In desperation, I consulted with the coaching staff, explained my concern, established my belief in weightlifting, but expressed my feelings that my son had already served his time in this type training and now must no longer lift weights. Of course they responded by immediately reciting the success stories about Pete Rose, Gary Player, Bert Jones; all of whom lifted weights. Feeling totally frustrated, I then decided I had to find out for myself and consulted by letter these three athletes plus the team physicians at Penn State and Ohio State. I also wrote to Ara Parseghian, Pat Haden, Archie Manning, Bob Griese, and the trainers for the Atlanta Braves, the New Orleans Saints, and others.

The remainder of this paper merely reflects their comments and I will leave it to the reader to draw his/her own conclusions.

On a Tuesday evening in June 1978, during the week of the National Open Golf Tournament, I received a long distance call. The caller said, "This is Gary Player." I was amazed, for he had just finished a practice round at Cherry Hills in Denver. He bellowed into the telephone with his delightful English Accent, "absolutely no bench presses, nothing with the shoulders, nothing with the biceps, nothing with the chest. You will ruin him, you will ruin this young man. Everyone thinks I lift weights, I don't." He then explained how he merely swings the barbell as a golf club, thus bringing all the muscles into play proportionately and not over-using one as opposed to the other.

Ara Parseghian, former Notre Dame coach, now TV commentator, admonished me about the skilled athlete. Strengthen his legs, nothing above the waist and use only upper body weights for therapy after injuries. His wide receivers and quarterbacks were always cautioned against lifting weights.

Pat Haden, Los Angeles Rams quarterback and a Rhodes Scholar, suggested light weights with repetitions to maintain strength. He stated that quarterbacks require both agility and strength; so weightlifting without proper supervision could be harmful. Pat lifts light weights, but with great care.

Archie Manning—"Weightlifting almost ended my

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career; I wanted to be the strongest bench presser on my high school team. It was actually an ego factor, now I know—running great distances, not lifting for strength but for conditioning, will prevent the binding of muscles."

Pete Rose—"You should be concerned with the amount of weight you lift, because you certainly can overdo it."

Bert Jones called and talked personally to my son on the phone for some twenty minutes. He essentially corroborated the others, except for one thing. He believed in weightlifting; but, conversely admitted he did little himself.

The physicians at Penn State explained that Coach Joe Paterno had his own coded program using the newest weight training Nautilus equipment. However, they also related how they could lift the weights assigned to the wide receivers and quarterbacks, but couldn't begin to budge the weights used by the linemen.

I could tell you more about the Ohio State program, the trainers with the Atlanta Braves and New Orleans Saints, Bob Griese, "Hopalong" Cassidy and others, but it would be mere reiteration.

In summary, communicating with great athletes, coaches, sports heroes, team physicians and trainers has afforded me the opportunity to develop some very exclusive pen pals. At the same time it has helped clear, "maybe", the many myths about weightlift training in the various sports. Moreover, trying to objectively analyze all the information has brought me to the following conclusions.

1) The bigger the man, the more he cares and seems to be genuinely interested in the youngsters who will be the stars of tomorrow.

2) Supervision in weight training is a must, and the aim should not always be to see who is the strongest.

3) The skilled athlete—catchers, batters, golfers, etc., must limit the weight they lift. Strive for repetition and quit once conditioning has been achieved.

4) Upper body (above the waist) lifting should be used mainly for therapy. Throwers should throw and catchers should catch, not lift weights.

Weight training will increase your son's athletic ability, confidence and strength. If he plays a skilled position, watch carefully. Talk to the coach. Don't let him end up being a Mr. America which could very well deny your son the full coordination so necessary to make life more fun in the later years, when tennis, golf, handball, etc. all become much more important outlets.

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A Perspective on World Records and the Medical Profession

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In retrospect, I wonder if I really knew why I wanted to go to medical school. Certainly my thoughts on the matter have changed during the arduous journey from Pre-med to M.D. Medical school is, to use the jargon, a hypertrophic finale to our educational system, a final step, from which we thrust ourselves upon the world, to carry its banner and we ourselves be its teachers. What, then, were the reasons we embarked upon this journey? Were they obvious and simple, or were they hidden and psychological forces, subconscious wants and fears, and various Freudian undercurrents that we always read about skeptically. Did we want to save mankind anyway and pursue lofty thoughts through the Halls of Hippocrates or were we more—like Christmas shopping and driven toward this goal by our own complex personalities. The answer is, I think, "All of the above," and more, and they are interrelated in as many ways as there are medical students and M.D.'s.

We find out early in medical school that the time for lofty thoughts is past, and mankind must wait at least

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until we finish to be saved. Our waking hours, and they are many, are filled with rote memorization, drawing blood, and holding retractors. We wince at the question, "Where is the medical student?" knowing it to preface but another attack upon our integrity as individuals with independence of mind and freedom of choice. This becomes a big issue. We easily fall prey to schizophrenic wonderings as to whether we have even the right to exist independently of "the system" and wonder if the freedom and independence of our earlier years were only illusions of time. It is an unfortunate fact that the medical school gives us so little of this time to re-evaluate our goals and reasons for pursuing them. Our very happiness is at stake. Our rational mind is constantly advised of its progress in transferring the gospel to short, and hopefully to long term memory. But what of the emotional toil in adjusting to a profession that was never quite as we expected it when we spoke so assuredly to the admissions committees. How do we extricate ourselves from the mad scramble of medical education and emerge in the end with a liveable set of goals in our chosen profession?

I am qualified to speak of goals. Before I was reincarnated as a medical student I had sought, and accomplished, goals in sports that had never been done before. Setting a world record of any sort, including a pole vault record, is a mental and physical elation of unbounded proportion. It is, in a single movement, the culmination of many hours of toil and dream, success and failure; somewhat akin to receiving a letter of acceptance into medical school or to walking across the stage at graduation and receiving that diploma. Yet after it's done, the elation remains for a long while to obscure the fact that the tide of accomplishment recedes and there is still another world record to be set, and then another, and indeed one must set and reset it again in small increments and at odd intervals until world records become as diplomas tacked on walls, or as photographs in albums, or as memories, however obscure and distant. One soon suspects that he will never set the ultimate world record and that perhaps it never existed anyway except in concept, as the object of a long sought goal. Linnaeus would have classified the world record as a hypothetical species akin in substance to some of the more idealistic reasons we as pre-meds wanted to go to medical school. You have but to accomplish the goal to realize its illusory qualities and that indeed most of the satisfaction was in the setting, not the holding, of the world record.

It is an odd twist to discover that these parchments of success are not harbingers of happiness. It was no easy task in medical school to see the physical abilities which allowed me to set world records dwindle, until I could but perform at a fraction of my accustomed level atheletically. Our medical school graduation was an interesting mixture of pure joy and relief of finishing, rooted in an underlying dread; terror even; of the most difficult road ahead. And to a soul, none of us would have relished reliving any single day as a medical student. Hard pressed we would have been to apply to medical school the analogy above of finding the greatest satisfaction in the traveling, not the arriving.

I think, in retrospect, the analogy still applies. The happiness of finishing medical school obscures our appreciation of little things along the way which subtly affect our happiness at that moment. Consider, for example, the task of starting an IV, which becomes a bane to the existence of medical students. When I was yet an amateur and sought help from a resident, often enough he finished with some patronizing remark about his expertise. Although he hated the task, he was still proud of his ability to do it. I am no different now. The analogy can be extended and applied to all of our medical skills and knowledge, without which we could never in good conscience consider ourselves physicians.

The analogy applies in sports. The physical pain of many of the workouts I have endured did not produce any sensation of immediate joy. Yet small improvements in my day-to-day performances were, in a sense, mini-world records for me, perhaps even more important than actually setting the world record. The conclusion is that being a world record holder, or being a physician, or being simply human is no end in itself. One cannot become or remain happy at any of these without somehow enjoying their pursuit. We can delay gratification for so long but to wish someday, we had lived more in searching for it. We should take heed Thoreau's personal admonition, "I went into the woods because I wished to live deliberately . . . and not, when I came to die, discover that I had not lived."

This is often a tall order in medical school, internship and thereafter. Thus we make this periodic re-evaluation of our goals and often enough realign our lives along more tolerable paths. I offer that this is healthy and good, and even, if we must, to change drastically the course of our lives and professions. Our entrenchment in "the system" is necessary to become and remain physicians, and our personal freedom is necessarily limited in other pursuits. But we must see that it is by choice we are there, and by choice we can yet pursue lofty thoughts, or strive to save mankind, or move in whatever direction available to find happiness. In medicine, as in sports, one can best handle his failures with an awareness of his limits, and one can best live with success by accepting those limits.

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Reflections of an Aging Runner

Rufus K. Broadaway, M.D.

A small black teenager finished the Orange Bowl Marathon this year. That his time was under three hours was impressive. Of more interest was his foot gear. He wore old-fashioned highlace tennis shoes, among the gorgeous Nikes, Adidases, Brooks and others, and it carried me back two or three decades to the time when those few of us who were strange enough to be running, then wore sneakers and knew nothing of traction soles, heel strike, orthotics and the like.

I did some tentative training with a small southern college track team before World War II. Much of that war was spent as a parachute infantry officer, in which the morning six-mile run was done in heavy parachute boots. This occurred whether rain or shine, sick or well, drunk or sober, dead or alive. Some sporadic running continued in medical school and residency, but it was after coming to Miami in 1955 that running, for me, became an established regular pattern. It has brought great joy to my life.

On a pre-dawn hour, along Old Cutler Road, in one of those early years, a Coral Gables policeman stopped me. Seeing me in white shorts and sneakers, he assumed me to be the neighborhood rapist. Having no identification with me, it took some time to convince him that I was on a health and exercise project. After he assured me that every cop in town was looking for me, he let me go. That was the day I set an unrecorded world's record for the two mile!

Prior to the leash law in this county, loose dogs were numerous. Most dogs, when pointed at and commanded in a loud firm voice to "GO HOME," go. There are individualists, however, among dogs, as well as doctors. Dancing between two barking circling German Shepherds while yelling "help" can be an exciting sport.

Most of my running has been done in the dark, since early morning is a dependable free time for a surgeon. Running in daylight, I feel exposed and self-conscious. I love the quiet and relative cool of those early hours. There are birds talking and singing, and some ducks in the canal along Red Road. In recent years the asphalt-covered bike trails have been marvelous running tracks. Prior to that, it was the streets. The morning stars, first light and sunrise are such special times and I've wished that the whole world could experience them.

Running should be fun, and it can be, if approached in that spirit. One can find all sorts of advice on equipment, training schedules, what to eat and drink, how to breathe, and so on. Much of this is good. A former intern reminded me recently that, some years ago, I urged him to run. He got shoes and shorts, started across a vacant lot, slipped and broke his leg, not 50 yards into running! I don't offer much advice except to go very slowly into this thing, set aside regular time, try to run with someone, don't buy very expensive equipment, and increase time and distance reluctantly.

There are those, who after a time, get caught up in running, and become competitive. And this serves a purpose if one realizes motivations and keeps some semblance of control. First competition is with one's self. There are many "Fun Runs" and one just wants "to see if I can finish." Many of the shorter races, 5 to 15 kilometers (3 to 9 miles) can be very enjoyable and serve to keep the training schedule intact.

When a medical student in Boston, I would see runners going around the reservoir, and was aware of the 26 mile run on Patriot's Day. I wouldn't have thought that 30 years later the race would have grown from 200 to 8,000 and that I would be among the pack. A marathon is a great experience and a Boston Marathon is a wonderfully exciting happening. The distance is much more than an endurance feat. It's something one works and trains for and then expends himself in this great outgoing of sweat and energy and emotion. Runners encourage each other and the enthusiasm of the crowd carries them along. And the finish is a matter of timing, and also elation and relief and thanksgiving and "I made it." As awful as those last miles might have been, there's an immediate soaring of the spirit, and this goes for the leader and for those who've taken twice the time to finish. Some of us bury our heads and weep with joy, and stay high for days.

The health benefits of regular exercise are no longer seriously debatable. Running is easy, inexpensive and effective. Runners, by and large, are not sedentary (by definition), don't smoke, lose weight, don't drink too much, and usually get interested in proper diet.

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Whatever that is! These fulfill the most important criteria for maintenance of good health. If half the people in this country ran, or even walked, ten miles a week, the effect on the cost of medical care would be tremendous.

As this is written, I can't run. I'm immobilized by a sore heel. A pesky bursitis hasn't responded to all sorts of advice and treatment. I don't feel whole. I feel as if a part of me has been taken away. Runners are said to become addicted. I know only that a run, whether it be a few blocks or many miles, gives one a sense of fullness and vigor. There's a peace that calms the mind (my associates say it's a de-oxygenated brain). How can one feel so great, full of sweat and nursing a blister?

Try running. You'll know.

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Napping Could be Next Craze

Erma Bombeck

Jogging.

It has almost been raised to the elevation of a sacrament. That's all people talk about anymore.

"Who told you about jogging? Was it your mother or your father or did you learn about it in the gutter?"

"Where were you and what were you doing when you heard that Jerome Drayton won the Boston Marathon?"

"Sure, I could go jogging with you this weekend—but will you respect me in the morning?"

Running around the streets wheezing has replaced handball, which replaced tennis, which replaced biking, which replaced golf, which replaced swimming, which replaced biking, which replaced golf, which replaced swimming, which replaced skiing as the national physical pastime. All of those are still in favor, but at one time or another they led the field in popularity.

It is safe to assume that jogging will pass and relinquish its trend status to a new sport. And what will replace it? Will there be life after jogging?

Of course, and frankly I wouldn't be at all surprised if "napping" replaced jogging as the No. 1 national sport. The momentum for any pastime is usually the same. It starts with a hero (astronaut, sports figure or movie star) who appears on a talk show and is asked, "How do you stay so thin?" and he or she replies, "I nap at least 30 minutes a day."

Small groups start at first. Then, a few stories appear where the AMA, to protect themselves, advises participants to get a complete physical before starting to "nap."

Books begin to come out—"The Complete Book of Napping," "The Complete Napper" and "The Napper's Handbook" (a Complete Guide for Men and Women Who Sack Out).

Napper's regulation shoes will come out with cushioned innersoles and fashions will reflect the sport with wrinkle-free slacks and polyester shirts that breathe when your body temperature goes down.

As the momentum builds, everything will point to the Napper's Marathon . . . The Napper's Olympics where nodders from all over the country will compete to see who can sleep the longest. There will be film clips of nappers "packing warm milk," taking deep breathing exercises, and talking of the "dreaded eyeopener" when you're pushing your body into sleep far beyond its limits. I can see Curt Gowdy spotlighting a man yawning and observing, "He's the man to beat."

I give "nappers" a couple of years at the top and then we'll be on to another sport—maybe stumbling.

Whatever it is, my body is packed with carbohydrates for it.

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Reprinted from Mrs. Bombeck's column, "At Wit's End," syndicated by Field Newspaper Syndicate.

Jogging for Fun and Physical Fitness A Hazard To Your Health?

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An exhilarating experience it is to feel like Hermes in a new pair of Nike or Tiger running shoes as you run, relaxing, easing your frustrations, socializing with your friends and competitors, but most of all working out to strengthen your cardiovascular system. The "road-runner's high" is, to be sure, the equivalent of John Denver's Rocky Mountain high, and provides each one with a better self-image, a greater concern and respect for others, and a healthy competitive spirit.

But, . . . watch out and beware, for even something so pure and simple as running has hidden obstacles which can dampen one's spirit, impair one's performance, or even incapicitate the smoothest of runners. I know because it happened to me, much to my disbelief, in spite of my obsessively compulsive precautionary measures. I am referring to the unexpected situations which can make running a risk, either because of a problem that occurs with the runner *per se* which he might otherwise control or modify, or because of outside influences over which he has no control.

Hazards of running, then, can pretty much be categorized into two groups: 1) problems that can be attributed *to* the runner and 2) problems that occur *in spite of* the runner and which are attributed to outside causes.

Hazards Due to "Runner Error"

Most of the misfortunes that befall a runner do so simply because of inadequate preparation or overestimation of one's capability. Unfortunately few of us are as loose and limber as we were 10-15 years ago during our college days when performing a variety of contortions was hardly a challenge. Those indeed were the good old days, and a lot of runners unfortunately don't realize this. As a result, their long distance run, if not preceded by a carefully planned and methodical warm-up of the legs, will be fraught with the risk of Achilles tendonitis, hamstring muscle pulls, and of paraspinous muscle spasm, occurring separately or in any combination. And don't forget about this risk on that cold day of 40° F when the runner uses no sweats. These, by far are the most frequent injuries affecting the serious minded jogger and can put him out of action anywhere from a few days to several weeks. Adequate warmup and stretching exercises before a run is essential preventive care for these injury prone areas.

Shin splits can be incapacitating—if we understood them better, we might be able to handle them more effectively. At least I learned that mine occurred when I alternated running on soft and hard surfaces. Before I matured and became the wise person I now am, I would run until my shin splits were so bad I had to crawl! It probably wasn't worth it. Exercises do exist to help improve as well as to prevent them. So, if you expect to be giving your legs a beating with different surfaces, do your self a favor and include the exercises in your daily workout.

Blisters are traditionally one of the greatest fears held by all runners, for those small devils can amazingly wreck havoc with one's ambition and make life miserable. It pays to treat your feet with tender loving care at all times—otherwise they will, to be sure, rebel and put you out of commission. Wearing new shoes for the first time at a race, especially if no socks are being worn, is a high risk situation for causing blisters at the lateral areas of the great and little toes. If the shoes are tight or quickly taper in the toe box, distal toe pad blisters frequently develop, especially if toe nails are kept too long. Fortunately Vaseline petroleum jelly strategically placed between toes minimizes the risk and alleviates the problem so that the avid runner does not have to break training.

Hazards Due to Environmental Causes

There are a few running hazards worth mentioning that can devastate the runner and which can occur *in spite of* him; not because of him. A common hazard is the irregularity of the running surface which leads to ankle twists. If the course is *au naturel*, be aware of topographical changes, debris or animal holes which can affect your footing. If the course, on the other hand, is a hard surface, then watch for potholes, for loose rocks, or for ridges which can cause ankle sprain or at least trip you

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into falling on your face. Above all, if you run any course in the dark, be sure you have *first* well acquainted yourself with it in daylight hours to help minimize this risk.

One of the more frightening experiences is the confrontation you may have with a neighborhood dog and/or several of his friends who decide you are trespassing into their area and proceed to chase you while exhibiting viscious sets of teeth and a powerful set of lungs. At times, in order to stop them from "attacking" me, I have turned around and chased them! But, it's to no avail, for they will merely turn around and chase you again. A confrontation like this is usually very sudden, and promises to maximize your adrenalin response, and certainly will make you seek another running route.

The sidewalk cyclist can be a real hazard, especially if he is daydreaming as he rides and does not see you, making you step off the path onto the shoulder with a sudden burst of energy to avoid physical contact with him or else jumping onto the handle bars to minimize the damage if impact is unavoidable. The runner has to have his eyes everywhere, on the road a few feet in front of him, a few hundred yards away, and on the surrounding areas well. Otherwise, his serene and rhythmical workout may be abruptly shattered.

The one unpredictable hazard, and perhaps the greatest of all risks to the runner is the vindictive motorist whose personality is one with a sadistic streak and/or disdain for the runner who is using the shoulder on the side of the road if a running path or sidewalk is not available. Be aware that anything ranging from empty soda or beer cans to bottles or rocks can come flying in your direction as the motorist and any friends he may have in the car with him drive by, along with a few verbal insults or obscenities. Finally, the worst and very real possibility is that the motorist may hit you, inadvertently or intentionally. The former is the usual situation and pretty much simply reflects careless driving. Some precautions which may protect you against this hazard include running as far off the road as possible, running on the side of the road facing oncoming traffic, and wearing light colored clothing or an irridescent vest/shirt when running after dark.

Fortunately most hazards of running result from something the runner has done wrong, hence allowing for potential prevention. One of the few beneficial physical activities which can be continued throughout one's entire life, running deserves a sacred place of honor among necessary exercises in which all people should become participants. When approached with the proper reverence and caution, running becomes a safe, healthy, addicting sport, guaranteed to give you the euphoric "roadrunner's high."

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The Female Athlete and Sportsmedicine in the 70's

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Introduction

The decade of the 70's has been one that has shown marked progression in the encouragement of women to enter sports. Beginning with the advent of the Women's Rights Movement in the late 60's and the finalization of Title IX in the early 70's, the push for women in sports began. With the increasing number of women in the thousands entering the sports world, physicians and allied personnel began to wonder what type of medical problems the female athlete was going to develop.

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Injuries

In 1973, the American Medical Association's Committee on the Medical Aspects of Sports rendered it's opinion that there was no reason why women should not be able to participate in any type of sport. In conjunction with this, they encouraged investigators to

look into the types of injuries that could be expected among women athletes, and the question arose whether these injuries would be any different from those that male athletes sustained.

As a result of this, in 1973, Ms. Joan Gillette Tannenbaum, the first woman certified athletic trainer, conducted a survey which was published in the "Physician and Sports Medicine"[1] of the athletic departments of over 300 universities and colleges throughout the country and she reported on the injuries at that time. At about the same time that her paper was being published, I had been requested to write an article for the American Medical Association essentially on the same topic, so I joined forces with Ms. Gillette and we did a second survey covering 1974-75 which gathered more specific details on the types of injuries and the results were then published in the July 1976 issue of the AMA Journal.[2]

Essentially we were able to show that the injuries sustained by women are, except for obvious anatomical differences, no different than those suffered by male athletes. The majority of injuries were to the ankles and knees with fewer fractures and head injuries since women were not participating in any great numbers in collision sports such as football and ice hockey. Women were, however, suffering more knee injuries, particularly chrondromalacia, and more shin splints and stress fractures. Part of this was due to a lack of knowledge of proper conditioning and the fact that women had not had adequate trainers and coaches. The rest was felt to be due to the difference in the wider angulation of the femur and knee in relation to the pelvis that also made women more prone to patella displacements.

Later studies conducted at West Point Military Academy showed that entering women who were put into a very vigorous sports program sustained a higher percentage of stress fractures than their male counterparts particularly when having to do forced marches carrying heavy packs.[3] Again this was felt to be a lack of conditioning.

An additional study done by myself, Ms. Tannenbaum, and Dr. Gail Shierman at the University of Oklahoma in 1975 revealed that while anatomical differences did account for specific injuries to the female that would not occur to a male such as contusions, abrasions, and hematoma's of the breast and contusions of the vulva, there were no significant different anatomical injuries sustained by the female.[4] A few odd injuries have been reported such as forceful douches occurring in water skiing causing lacerations of the perineum[5,6] and hematomas of the vulva occurring as a result of a slip on the balance beam, but these were not life threatening.

Many myths had to be laid to rest in regard to the breast, especially the myth that a blow to the breast might result in cancer. Perusal of the literature and our own investigation could sustain no relationship. Our study did demonstrate the need for an adequate supportive bra for the woman athlete, particularly those with larger breasts.[7] Sports such as jogging and basketball where there was considerable up and down motion caused pain and tenderness of the breast tissues due to stretching, chafing of the skin due to rubbing by poorly constructed bras, and irritation, cracking and bleeding of the nipples due to the rubbing of bras or clothing, particularly the seams found in some bras. Subsequently manufacturers have developed adequate supportive sports bras which are now available for the female athlete.

Obstetrics and Gynecological Aspects

Other areas of particular interest are in the obstetrics and gynecological aspects of women in sports. Early studies published in the literature tended to indicate that the athletic woman had less menstrual problems than her non-athletic counterpart, but real clinical evidence was lacking.[8,9] With the participation of many women, particularly young girls into jogging, it became apparent that amenorrhea was resulting when women were placed in very stressful athletic situations. Many young girls had a delay in the onset of their menses and other young women found that they became amenorrhic when they were in severe training for marathon runs. This question was also looked into quite closely at the Military Academy, particularly at West Point with their first women plebes, and interesting statistics emerged.

Of the women studied at West Point, about 15% of the women admitted to having some menstrual dysfunction when they arrived at the academy. At the end of a 2 month period, approximately 75% of the women were amenorrhic; however with the progression of time this number gradually fell to the point that most of the women regained their periods and only about 7% indicated any dysfunction in their periods. In general most of the women felt that their periods were shorter and less painful after they had adjusted to the routine.[3]

The reasons for this phenomena have been widely discussed and there are a number of theories. One theory was that it is a loss of body fat, but most of the other investigators feel that it is a stress phenomena based on hypothalmic depression which reduces the output of luteinizing hormone (LHRH). This in turn causes decreased release of follicle stimulating hormone (FSH) by the pituitary gland which reduces the ovarian steroids produced by the ovaries resulting in amenorrhea. Other investigators feel that it is a combination of both events in as much as the mobilization of fat in the woman athlete utilizes estrogen.

Whatever the cause, it does not appear to be of any

serious consequence. Any let-up in training or cessation of stressful activities results in the return of the period. I have seen several women in my own practice in past years who have lost their periods when there has been a death in the family, particularly the loss of a father or mother, where the amenorrhea has lasted as long as two years. I recall one young lady who only regained her period when she met and became engaged to a young man. So in reality this is not a new phenomena.

There have also been a number of studies in the literature on the possible effects of athletic activity on pregnancy. To date no adverse effects due to strenuous physical activity have been demonstrated during pregnancy and several runners including Kathleen Kraham, who was an Olympic medalist, have continued to jog as much as five miles a day right up until the day they delivered without any apparent adverse affects. Several such reports concerning pregnant women athletes have appeared in the literature and none of these report any ill consequences.[10,11,12]

A report from Chicago widely circulated by the newspapers suggested that procidentia (cystocele and rectocele) might be caused by women jogging because of the pounding of the feet on the surface of the road and consequent stretching and the sagging of the pelvic ligaments. In reality, stress incontinence is not an uncommon finding in women joggers, many of whom who have had two or more children. I have personally seen two such cases and both have responded well to early repair. I feel quite strongly that the cause is not the jogging, rather that weakness and stretching of the fascia and muscles occurred during childbirth. The resulting stress incontinence is simply being brought to light earlier in women who would develop it anyway in the 50's and 60's by their jogging. I find this to be a positive occurrence in the sense that a repair early (assuming that the woman is not planning any more pregnancies) is a better one because the tissues are generally healthier.

Physiology

Physiological studies in areas such as oxygen uptake and muscle strength are being carried out on women. It is known that women have less oxygen carrying capacity due to smaller lungs and less hemoglobin. However, with training this can be overcome, and the fact that this is so has been born out by a number of races which have been run over a 100 mile course. The women runners have not only finished, but in several instances have won the race. It is advised, however, that women athletes check their hemoglobin levels to assure that if they are having heavy periods with resultant iron loss, this be replaced by an iron-vitamin supplement.[13,14]

It is also prudent for the physician to keep in mind that many women may be either hypo-or hyperthyroid and should any suspicion arise in either instance, clinical studies should be performed. Supplementing the hypoactive thyroid patient will indeed increase her performance, and medical treatment of the hyperthyroid patient certainly should be instituted.

Another common myth that has had to be exploded is that women who train using weights will develop bulging muscles. As physicians we know that this is not possible unless a woman has an unusually high testosterone level. Without testosterone, no matter how much a woman exercises or pushes weights, she will not develop bulging muscles. Her muscle strength can be greatly increased by exercise and weight lifting, and in fact there are now women who are actually partaking in weight lifting competitions. These women will develop slightly larger muscles in their shoulders and arms, but if the exercises are carried out properly, all of this will be proportional, and these women will not become unsightly. Weightlifting is being encouraged for women tennis players, for example, to strengthen their upper thorax.[15]

Geriatrics

Physcial fitness is not only being widely encouraged for our young women patients, but is being widely encouraged for geriatric patients. There is certainly no known contraindication to the continuation of all sporting activities following menopause. In fact, physical exercise should be encouraged as a psychological adjunct to the patient's well being during this period of life. I have seen an instance in my own office of a severly depressed post-menopausal patient who began to jog, and after she had been doing this for approximately four months, she was no longer in need of antianxiety medications. There have been many excellent publications on this subject that go into depth in dealing with the encouragement of our older citizens to exercise and keep fit. Inactivity is probably the worst enemy of this age group.[16]

Conclusion

In summary, the decade of the 70's has been an interesting one in the development of athletics for women in the United States. The decade of the 80's should see increasing numbers of women participating in all sports, and in the opinion of most investigators this is a very positive phenomenon which should help result in a healthier population with generally fewer problems for physicians. While we must be certain that our athletic patients are receiving the best of care and are not carrying out activities detrimental to their health, we should be in the forefront to encourage physical activities and indulgence in sports as a means of preventative medicine.

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Physical Fitness and Today's Teenage Female

Ann Rousseau

Physical fitness is being able to run faster than you walk.

It means being able to use ones' body with ease.

It means being in shape, not being overweight.

It means feeling healthy.

These are responses which were given by girls ages 12 through 17 when asked, "What does physical fitness mean to you?" And to the question, "How do you judge if you are physically fit?" they replied: "I know that I am physically fit when I'm ready to do things and if I'm not tired or breathless. I'm fit because I am limber and not overweight, my body is firm. When I can do what the average girl my age can do." A majority of the girls surveyed felt that being physically fit meant being able to exercise without straining muscles and being able to run without tiring quickly.

But the American Alliance for Health, Physical Education and Recreation, (AAHPER) considers a girl to be physically fit when she can attain a predetermined degree of proficiency on each of six specific skill tests. The events are designed to evaluate arm and shoulder girdle strength; efficiency of abdominal and hip flexor muscles; speed and change of direction; explosive muscle power of leg extensors; speed and endurance. The test items, when taken together, give an over-all picture of the physical status of today's teenage female. It is the only test of its kind with established national norms.

Although the girls had a general concept of what it meant to be physcially fit, few were aware of the components of a physically fit body. And few were involved in any regular exercise program which would insure a high degree of fitness. Many believed that jogging was an activity which would make them totally fit; however, if you are to use the criteria established by the AAHPER, any singular activity will not, in itself, insure total fitness.

The girls had an overwhelming desire to be physically fit. The main reason was that they would feel better. Important to many of them was the idea that their appearance would be improved and therefore they would be more popular, but yet these girls weren't on any regular exercise program because, "It's a pain." "It's boring." "I don't have time."

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When asked the question, "Who should be responsible for seeing that you are physcially fit?", the majority of the girls responded by saying, "It is my own responsibility." A few felt that maybe their parents should be of some help. But from observing young females today, it might be concluded that making them responsible for their own fitness would be less than advisable. And judging from the number of notes physical education teachers receive from parents excusing their daughters from class, it is questionable if a parent is always a good judge of what is in his or her child's best interest, physically.

So then by what means and by whom is a better awareness of the necessity for proper physical fitness for today's young women going to be promoted? It is strange that in answering the question of responsbility, family doctors and physical education teachers were rarely mentioned, and yet these two groups are especially well qualified.

Members of the medical profession together with physical educators, working within the framework set by the various school systems, are going to have to educate the girls and their parents. They will have to be taught the importance of being physically fit, its components, and how to plan a beneficial program.

Setting and attaining goals is an accepted motivational technique for learning and for behavior modification. With some planning and imagination a goal attaining program could be devised for every child in a school system, if we would be willing to commit ourselves to such a course.

Cooperation and dedication are the key; now we need to develop an effective method. The pediatrician, perhaps, holds the key to success. He needs to educate the new mother on the concept of total fitness. Making time for a fitness routine daily needs to be established as a habit for the growing child. The yearly physical examination for school should be expanded to include a complete testing of the fitness components. Any deficiency should be noted and sent to the attention of the physical educator. Specific exercises would need to be given to the parent to supervise and a follow-up scheduled with the doctor.

The school systems need to commit more funding to the physical education program in order to provide a daily program for all students. The physical education teachers need to commit themselves to setting up and following through on a goal oriented program for every student.

Self-discipline is needed on the part of the girls if they are to fulfill their desire to be physically fit, however, physicians, school systems and physical educators are going to have to devise a plan which will motivate these girls to attain that goal.

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Physical Fitness and the Child

(One Pediatrician's View)

Dale F. Zimmerman, M.D.

It seems appropriate that the editors of *The Journal* would invite a pediatrician to write about physical fitness in children. Yet, when I was asked to commit my thoughts to paper for publication, my reaction was panic!

What did I really know about this subject? My medical training was disease-oriented. It was assumed that if one knows all about disease, he can care for well children merely by certifying the absence of illness. Thus, I received no formal instruction as to what constitutes fitness in a child.

Be that as it may, I often deal with this subject in the course of my practice. People today are *health oriented.* It is not enough for them to know that they are well; they also want to know what they must do to *remain* well.

The public mind has begun to equate improvement in physical fitness with increased longevity. The general attitude is that if one eats the right diet, takes the proper vitamins, maintains muscle tone, he might delay or retard

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the onset of old age. Indeed, a few seem to be grasping for immortality.

As a pediatrician, I see many children whose parents, in the interest of fitness, have put them on regimens that include unappetizing diets (e.g., low sugar, low residue, low fat, dye free, etc.) or exercise programs that would make a Spartan proud. I recently examined a nine-year-old boy who runs 15 to 20 miles every day!

So, I cannot ignore the subject, nor can I assume a negative attitude and discourage all parental attempts to improve their children's fitness. Such an attitude would be highly unpopular; and then too, I also am somewhat caught up in the national spirit, having been seen all too often forcing my protesting body to cover the length of the local jogging trail. But, when it comes to answering patients' and parents' questions, I feel I must base my responses on what has been proven scientifically about the subject.

Benefits of Fitness

As far as I know, no one has ever shown conclusively that being able to run five miles in less than 30 minutes, or to perform any similar strenuous activity will increase lifespan by any amount. There may, however, be some psychological gains to being fit. One certainly is led to believe this when athletes speak of the "highs" they achieve while performing their sport, or when psychiatrists claim successes in treating depression with exercise programs. Obviously, a child's developing ego gets a lift when he acquires the ability to perform a feat of strength or endurance that was previously beyond his reach. And, the recent discovery of opiate-like substances released in the brain by exercise may lend some physiologic evidence to support claims that exercise improves "mental outlook."

On the other hand, I have some reservations about the degree of emphasis which may be placed on physical fitness in some school programs. While the majority of the students may benefit, I am concerned about the not insignificant number of children who are inherently awkward. I am referring not to those children with obvious crippling defects but to those otherwise healthy children who simply are born with a lack of coordination which will not greatly improve through any amount of training.

Unless programs are structured to provide activities in which these children can excel, how can they not suffer emotionally from being doomed to failing at something they have been indoctrinated to believe is essential for their future well being? As a pediatrician, I sense an obligation to screen out this population of children early so that their parents can direct them toward some type of physical activity in which they can achieve some success.

I certainly do not believe that fitness programs should be eliminated from the schools for there are other children lacking in academic ability but adequately endowed with at least normal physical ability for whom fitness programs provide an opportunity for success and peer acceptance within the school setting. My point is that we must look carefully at what meaning we are attaching to fitness for our children.

What Constitutes Fitness

Let's examine what actually constitutes fitness in a child. We pediatricians see some children who are overweight and could not run a city block without becoming short of breath. I feel comfortable in stating that these boys and girls are not "fit." Then, there is a smaller group of children, like my nine-year-old marathoner, who probably are "fit." But, for the vast majority of children whose body fat is in within normal range and who have no trouble keeping up with their peers, what should we say constitutes "being in shape"?

Many of us are familiar with the guidelines from the President's Council on Physical Fitness which state, for example, that for a nine-year-old boy to achieve the 90th percentile on a fitness test, he should be able to do seven pull-ups, 44 sit-ups, broad jump five feet 10 inches, run 600 yards in under 2:04, etc. I don't know how these standards were developed, but if children nationwide are tested by them as planned, we will have at least one method to quantitate fitness. But perhaps because of my disease-oriented training, I still wish for some blood test, enzyme assay or quantitable measure of some physiological function which would allow me to measure fitness.

Harmful Aspects

There is also the question of whether a child can pursue fitness to the point of causing some future physical harm. For example, will my nine-year-old marathoner develop early degenerative arthritis as a result of his running habit? On this question I can only plead ignorance and engage in conjecture. Physicians involved with the health care of children have observed that active boys and girls often suffer from the so-called "overuse syndromes"—i.e., tendonitis (tennis elbow, swimmers shoulder, joggers heel); apophysitis (Osgood-Schlatters, Severs disease); and chondromalacia. For these maladies, usually a prescription for rest until asymptomatic, exercise to strengthen supportive muscle groups, and gradual return to exercise to tolerance will solve the problem. But as for possible *long term* effects of repeated trauma on the developing musculoskeletal system, not all the answers are in.

There are other areas of concern to physicians within the general topic of fitness in children, such as the effect of exercise on various disease states. For example, how should exercise be regulated in children with various congenital heart lesions? Or, how

should insulin dosage be adjusted for the diabetic athlete? People much more knowledgeable than I have offered opinions on these questions elsewhere, and I will not puruse them further here except for one: the effect of exercise on asthma.

The large number of children in my practice with reactive airway disease is quite amazing. As they mature, most of these children lose their overt wheezing but, on close questioning, will report a history of exercise-induced cough or dyspnea. I mention this because in my experience it is a very common problem that can be frequently overlooked unless one specifically questions older children who, as toddlers, had a tendency to wheeze with respiratory infections. An inhalation of cromolyn sodium or metaproterenol prior to activity will often greatly improve these children's exercise tolerance, and subsequently their attitude toward fitness.

Conclusion

In conclusion, we physicans should actively support a national program to improve fitness in youth. We should offer our advice and knowledge to those developing physical fitness programs for children, and we should use our expertise to research and find answers to the questions about the effects of exercise on children.

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The Physically Fit Child

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Abstract: Existing scientific literature suggests that in Western culture the healthy but inactive child may be physically unfit. Recently acquired laboratory data support this and specifically identify superiorities in athletically trained children as opposed to sedentary counterparts relative to maximal oxygen uptake, pulmonary function, exercise cardiac output and physical working capacity. Although it is recognized that not every child need be an athlete, current knowledge indicates that individuals between ages 8 and 10 should demonstrate a physical working capacity at a heart rate of 170 bpm of at least 300 killogram meters per minute (kgm/min) and that this value be 450 and 600 kgm/min for those from 11 to 13 and from 14 to 16 years respectively. We suggest a simplified physical working capacity test be an aspect of periodic physical examinations of children, and further recommend an assessment of body composition via skin fold measurement be included as well.

Introduction

The human body is not only designed for physcial activity, but requires it for normal development and maintenance.[1] However, present society is far more conducive to a sedentary life style than to an active one.[2] Thus, we are accustomed to the fact of hypokinetic disease in our adult population.[2] That children may suffer the same malady is less frequently considered since children, by grown-up standards, seem to be active indeed.

Perhaps the first question to ask is "Fit for what?" Not every child need be an athlete; for some, striving in such a direction might well be a tragic waste of talent of another nature. In fact, the child must be fit enough only to assure normal function and proper development. Unfortunately, many children, misdirected by protective parents and hypnotized by television, fail to achieve even these minimal levels.

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Oxygen Utilization and Cardiorespiratory Fitness

If one were to select the best single estimate of cardiorespiratory fitness currently available, the choice would be maximal oxygen uptake (VO_{2max}), the amount of oxygen used by the body during the heaviest sustainable physical work. A low VO_{2max} suggests a weak link in the oxygen delivery system; *i.e.*, inadequate function of heart, lungs, blood vessels or blood pool. This test requires full effort from the patient and is, therefore, unsafe for certain individuals. Furthermore, such measurement utilizes expensive equipment and technical assistance. Nevertheless, data exist to demonstrate that the mean VO_{2max} in normal untrained children is significantly less than in those with excellent exercise habits.[3] We recently measured child competitive swimmers ranging in age from 8 to 16 years and found the mean VO_{2max} to be 54.67 milliliters per kilogram of body weight per minute (ml/kg.min-1) (Table 1). The VO_{2max} in normal but untrained children of this age span is usually about 43 ml/kg.min-1.[4]. Furthermore, in our group of swimmers, VO_{2max} continued to increase over a three year period of intensive physical training, illustrating that development of full potential is a long range goal.[5]

Pulmonary Function as an Aspect of Fitness

Standards exist for lung volumes in children.[6] It has been estimated that number of alveoli increases with age through eight years.[7] Studies of lower animals indicate that frequent regular physical activity taken during prepubertal months elevates the number of alveoli finally achieved in adulthood and results in a significantly larger total lung capacity than otherwise anticipated.[8-10] We have found that physically active children exhibit mean forced vital capacity 109 percent of their predicted normal mean.[5] Perhaps normal values have been established from a population devoid of those with superior pulmonary function, and thus we are willing to accept a low value as normal.

The VO_{2max} is partially dependent upon pulmonary diffusing capacity (D_L). Although it has yet to be directly shown in children, in adults D_L is sensitive to physical training.[11] Table 2 presents data from age, sex and size matched subjects, youthful competitive swimmers versus those untrained. Although the sample is necessarily small, being limited by the number of available trained children, it can be seen that as a group the swimmers possess significantly greater mean D_L both at rest and at exercise than do the normal, healthy but sedentary counterparts. There is no way to know whether the swimmers improved D_L through physical training or if they brought a high level of respiratory function to practice on day one. Nevertheless, the difference between extremely fit and "normal" in this parameter exists and is probably based upon quality of cardiac function, as well as extensiveness of alveolar membrane surface area and hemoglobin concentration.[12]

Cardiac Ouput in Children

Evaluation of reported values of cardiac output (Q_C) in children is difficult. Directly measured Q_C has been done in the main in patients without normal function. Bloodless methods seem inaccurate at rest.[13] Exercise Q_C measured indirectly appear accurate,[13] but data are sparse. Table 3 contrasts the exercise Q_C of physically

Table 1.-VO_{2max} in child athletes

Subject	Sex	VO_{2max},ml/kg min-1
1	F	56.21
2	M	66.78
3	F	46.71
4	M	54.94
5	F	44.77
6	M	58.61
7	F	47.43
8	M	66.49
9	F	39.44
10	F	45.89
11	F	53.47
12	M	68.83
13	M	63.94
14	M	68.24
15	F	44.31
16	M	45.82
17	M	46.18
18	M	58.24
19	F	53.18
20	M	60.79
21	M	57.73
X	—	54.67

Table 2.—Pulmonary diffusing capacity for carbon monoxide (DLCO) in child athletes and normal controls

Rest DLCO,ml/min/mmHg		Exercise DLCO,ml/min/mmHg	
Normal	Swimmer	Normal	Swimmer
11.28	13.27	27.69	39.05
12.92	22.50	25.31	51.74
10.61	16.65	38.82	27.25
10.74	14.27	37.74	39.11
11.26	16.25	37.85	36.73
16.42	30.86	36.12	46.45
20.69	25.50	43.62	45.06
17.72	30.68	38.24	68.98
22.42	25.89	42.37	38.27
27.09	24.57	42.85	51.49
29.83	26.97	44.08	62.75
24.58	21.38	31.95	50.17
27.73	34.13	52.20	57.75
X=18.71	23.30	38.37	47.29

Table 3.—Cardiac output (Q_C) at exercise in child athletes and normal controls

Exercise Q_C, l/min	
Normal	Swimmer
8.10	19.83
15.25	20.23
11.40	16.76
12.04	11.22
13.89	22.17
13.49	17.75
14.27	17.35
22.70	30.01
X=13.89	19.42

Table 4.—Physical Working capacity at heart rate 170 bpm (PWC_{170}) in child athletes and normal controls

PWC 170, kgm/min	
Normal	Swimmer
300	450
450	600
450	450
450	450
450	600
450	600
450	750
600	750
X=450	581

trained children against that of healthy but sedentary counterparts. The Q_C was measured at a heart rate of 170 bpm by means of carbon dioxide rebreathing.[14] This illustrated difference in mean Q_C at exercise is significantly greater in the active children.

Physical Working Capacity in Fit and Unfit Children

Physical working capacity (PWC) is a convenient, submaximal and safe means to assess fitness in children.[15] It clearly reflects VO_{2max} as well as muscular strength and endurance.[16] Measurement of PWC requires minimal and inexpensive equipment.[17] Shephard[18] and Anderson *et al.*[19] have noted higher PWC in active healthy children as opposed to normal but sedentary youngsters, and in those suffering pathology of heart, lungs, blood vessels and blood pool. Data from our laboratory (Table 4) show exceptionally fit children to significantly exceed normal school children in PWC terminated at a heart rate of 170 bpm (PWC_{170}). It should be noted that Table 4 reflects data derived from paired subjects matched on criteria of age, sex and body surface area, the sole variable factor being habitual physical activity level.

Psychological Considerations

It has been hypothesized that adult pressure to excel damages the psyche of the child who attempts to achieve physically.[20] This may well be true, but when the child is allowed to progress toward logical goals without undue leverage from parents, coaches and peers, only desirable psychological alterations seem to acrue.[21]

Efforts to examine the effects in later life of early involvement in physical activity reveal that what one does in the present is of greater importance than what has been done in the past.[22] However, it is here suggested that when good exercise habits are introduced in childhood and are pleasant experiences, they are likely to persist throughout adult life.

Summary

Existing data indicate that quite fit children between ages of eight and 16 years show a VO_{2max} of between 40 and 65 ml/kg min-1, an exercise D_L of from 30 to 65 milliliters CO per minute per millimeter of mercury pressure (ml/min/mm Hg), an exercise Q_C at heart rate 170 bpm of from 15 to 30 liters per minute (l/min) and a PWC_{170} of from 450 to 750 kilogram meters per minute (kgm/min). Such values are in excess of those from the common population.

Measurements discussed thus far in this paper are difficult to make. For this reason it is suggested that a simplified PWC_{170} test be an aspect of the child's physical examination. Children between 8 and 10 years of age should be expected to pedal the bicycle ergometer[17] for six minutes at 300 kgm/min before reaching a heart rate of 170 bpm. This work load should be 450 kgm/min for those between 11 and 13 years of age, and 600 kgm/min for children from 14 to 16 years old. Such standards would be representative of adequate physical fitness, incapable of achievement without proper development of the oxygen delivery system.

Finally, our children are too fat.[23] A simple skinfold measurement would allow the physician to estimate percent of body fat.[23] It is suggested that boys under 16 years should measure less than 20 percent fat and girls of the same age less than 30 percent to indicate a body composition commensurate with reasonable fitness status.

For those children who cannot demonstrate body compostion and/or PWC_{170} equal to these minimal standards, a prescription of increased physical activity is often indicated.

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Basic Diet Guidance for Athletes

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Performance is the common denominator of the articles in this series. Performance, as you will soon appreciate, depends upon the state of readiness of the muscle-tendon mechanism that powers motion. Assuming other factors (training, ability, size, strength, coordinative skills, and the like) to be equal, it is diet that makes the difference in the performance of a world-class athlete. It now seems that it determines what happens in that last one-tenth of a second for runners and swimmers, or that last one-half inch for jumpers and throwers, or that extra ounce of energy that is needed for a champion in the strength events. The articles we have written for *Nutrition Today* examine in depth the cellular physiology and biochemistry of muscle action and discuss the utilization of foodstuffs to produce the fuel for muscle action. Here I would like to set the stage by discussing some of the basic principles that we in sports medicine consider when we contemplate the role of diet in athletic performance. They are fundamentals that the non-athletes among us will find well worth thinking about. We will discuss the basics, with some restatement for emphasis.

In nutrition for athletes, there are six classes of substances to be considered. Each is important. Each provides the body with a vital ingredient, without which performance declines. In the competitive world of athletics, things are ranked in order of importance. Therefore, I would personally rank them thus: water, fats, carbohydrates, proteins, vitamins, and minerals.

The normal, average, well-trained, thoroughly conditioned, human adult is about sixty to sixty-five percent water. Water is the most mobile, the most frequently depleted, and the easiest to restore of all components of the human body. In hot weather and during heavy exercise, water is lost very rapidly from the body, so it should be replaced at frequent intervals.

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Water is needed for the control of body temperature, for proper functioning of enzymes, for digestion and metabolism, for elimination of nitrogenous wastes, and for transportation and utilization of nutrients (glycogen) in the muscles.

When more than two to three percent of the body's water is lost, performance declines. While we may not know a foolproof way to improve performance in every individual in every instance, there is no question there are three ways to decrease performance: starvation, dehydration, and fatigue prior to competition.

In the area of prevention of injury to athletes, the most serious consequence is, of course, death. Although it is sad to say, competitors die during athletic events of causes that can be prevented. Dehydration, as a result of heat injury, is one of these. Such tragic events occur frequently during late summer or early fall. Prevention is, of course, simple: water in adequate amounts *before*, *during*, and *after* practice or competition.

Fat is the fuel most frequently used by the body to power muscles. The body stores fat in an almost inexhaustible supply. In conditioned athletes, most submaximal effort is fueled by fat—up to sixty to seventy percent of maximal effort in aerobic exercise. Above seventy percent of maximal effort and when the exercise becomes anaerobic, the body turns on the carbohydrate fuel line. The muscles then burn a mixture of carbohydrates and fats. As anaerobic exercise continues, the mixture turns leaner, and finally, in an "all out effort" carbohydrates take over completely as the fuel. Why? Because it takes more oxygen to burn the fats than it does to burn carbohydrates. During maximum exertion, the muscles demand so much energy that the oxygen supply cannot meet the demand.

As a fuel for exercise, carbohydrate is used inversely with the oxygen supply and by the muscles during bursts of speed, or the final "kick" at the end of an endurance event. Carbohydrate is stored in the body and mobilized for use as needed. It is stored in the liver—110 grams, in the muscles—250 grams, and in the blood—15 grams. There is a total of 375 grams of glycogen in the body.

The question of how far one can go on a gram of glycogen is not easy to answer. It depends on the rate of energy expenditure. With a maximum effort and full glycogen stores, the best answer is "not very long," or fifteen seconds to two minutes. Glycogen loading is discussed fully in Dr. Vitousek's article elsewhere in this issue.

Protein is the least important nutrient for energy expenditure. While you are sitting, reading this article, you are expending as much protein for energy as you would if you were running around a track. Protein is used as a fuel to power muscles only in starvation. This is not to be misunderstood, for protein is an essential part of every diet. It is needed to build and to repair tissue, especially in the muscles. It is needed for the production of hormones, for the proper function of enzymes, and for the development of antibodies. The importance of the brain proteins, including endorphin, enkephlin, and other brain proteins, and their role in athletic performance, is only now beginning to be studied.

The "non-fuel nutrient" is what Dr. R. J. Williams calls vitamins and minerals. For years we have referred to the use of vitamins in athletics as the classic example of the "high octane" theory in the care and feeding of athletes—"more is better." Some athletes take vitamins by the handful, like popcorn. Although I have not actually counted, a very reliable source tells me that a member of one of the current groups of international class athletes takes seventy-seven pills (mostly vitamins) at breakfast every day! Many athletes take three or four vitamins a day.

The toxic effects of the ingestion of excessive amounts of vitamins A and D are well known. Vitamin E, another of the fat soluble vitamins, is a current favorite around the gym, and it must have a toxic level, but fortunately for the athlete, that level is so high we haven't recognized it yet.

There may possibly be a need for vitamin B complex supplementation in rare cases, as Conzolazio indicates in his writing, but very small amounts are adequate, if needed. The megavitamin philosophy has no application in sports. If one eats a normal American diet, one gets all the vitamins needed to be a healthy, young adult. Taking more is not only a waste of money, but may, in the case of the fat soluble vitamins A, D, K, and E, be injurious to health. Excess of the water soluble vitamins is excreted in the urine, which leads to the old story I've heard at the Olympics among my medical colleagues from other countries: How does one identify an American athlete in international competition? "Easy. He's got the richest urine in the world. It's full of vitamins."

Heavy exercise in hot, humid weather can cause one to lose (through perspiration) up to 400 milligrams of sodium chloride (salt) a session. The average American diet contains between 100 to 300 milligrams of sodium chloride a day. The average Olympic athlete will consume from 4,000 to 5,000 calories per day, and this will provide considerable sodium chloride. Even so, however, he should be advised in hot weather to sprinkle a little extra salt on food, and have at least one salty item with each meal. Canned soup, consomme, saltines, salted nuts, ham, bacon, corned beef, processed meat, or cheese helps fill this need. Salt tablets are to be avoided. They drain water from the tissues into the intestinal tract, and often produce nausea. The dose that is recommended on the salt tablet box is so far in excess of the need, that it is dangerous.

Potassium, also lost through perspiration, is adequately compensated for in the regular diet. During heavy exercise in hot weather, an extra banana, apricot, or baked potato (including skin) is enough to make up the possible deficiency.

Iron is also lost in perspiration, but in general not enough is lost to require replacement with supplemental iron.

As for the substances designated as "trace elements," their number is legion, and their importance as a supplement for athletes is overrated.

Potassium, calcium, iron, copper, iodine, magnesium, manganese, molybdenum, chromium, selenium, cobalt, zinc, glycine, and amino acids each have at least one guru with a special dietary program. These nutrients are all supplied in adequate amounts in a normal, balanced diet. Mineral supplements are unnecessary.

The diet of a 125-pound American woman or a 170-pound American man supplies an average of 2,600 to 3,000 calories a day. An athlete in training may take in up to 5,000 calories a day, and most expend enough energy to maintain a steady weight. But even these individuals have to watch their weight, especially during the off season, when eating habits may produce an excess of caloric intake over energy expenditure.

Athletes receive most of their nutrition information from coaches, trainers, and peers, and these individuals can best guide the athlete toward sound nutrition habits. These are the people who can discourage dietary fads, the injudicious use of special supplements, and the dependence on pills and gimmicks. Basic nutrition advice can be helpful to the athlete all his life, and if heeded, fewer ex-athletes would say, "Yes, I played football, but that was 100 pounds ago."

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An Orthopaedist's View of Aerobic Running

Dempsey S. Springfield, M.D.

Running has become a part of my life. More specifically, aerobic running has become a part of my life. Aerobic running is running without the production of an oxygen debt. In practical application, it is running at a pace during which you are able to converse comfortably. Aerobic running offers me a method of obtaining physical fitness, and it is the physical fitness that I value.

Physical fitness benefits me throughout my day and night. My cardiovascular system works efficiently, my lungs breathe easily, my weight is controlled, and my muscles are toned. This physical conditioning is associated with improved sleeping habits, more energy during the day, and a confidence in my body previously not experienced since my high school athletic days. Associates who share my enthusiasm for physical fitness agree with the benefits but do not necessarily agree with my methods of obtaining and maintaining this fitness.

The Author

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Dr. Ken Cooper[1] should probably be credited with pointing out the benefits of aerobic exercise as a method to improve cardiovascular fitness. He provided a means of measuring one's own level of cardiovascular conditioning and suggested programs to improve this physical fitness level. Dr. Cooper's goals were designed to provide an acceptable level of fitness with minimal time and effort. Aerobic running was one of the programs Dr. Cooper suggested, but he also recognized the value of walking, rope skipping, stair climbing, swimming, cycling, or stationary cycling. All required 20 to 30 minutes per day, five to six days per week.

Each of the programs have their advantages and disadvantages. I would like to discuss the advantages and disadvantages of aerobic running. My comments are based on my own experiences, the experiences of my patients, the information published in the running literature and accepted orthopaedic principles.

The major advantage of aerobic running is convenience. No partner is needed; no court time must be scheduled; weather is a minor factor; time of day is unimportant; and a minimum of equipment is required. Special skills do not need to be acquired, and improvement is easily measured. Forty-five to 60 minutes a day is all that I need to stay in top condition. My own program is

worked into my schedule with only minor planning.

The disadvantages are few and related to the level of involvement. Injury is defined as any ailment which interferes with running. The incidence of injury is related to the intensity of training. The risk of injury is minimal if one restricts his level of training to 30 minutes a day, five days a week; and at this level, excellent cardiovascular conditioning is realized. As the intensity of training increases to 75 to 90 minutes a day, seven days a week, the risk of injury is dramatically increased. If one wants to reduce the injury risk at this level of training, one must be extremely cautious and adhere to accepted guidelines of weight training and stretching.

Injury to the musculoskeletal system occurs because of over-stressing the system, disproportionate development of muscles, or a basic anatomical abnormality in the musculoskeletal architecture. Recognizing the separate category of injury provides both a guideline for preventing and treating these injuries. Let's examine each separately.

The most common underlying cause of musculoskeletal injury in a runner is overuse. The runner in his or her enthusiasm does not allow adequate recovery time between exercises. Building muscular strength and endurance is accomplished by stressing the muscle towards its limit, then allowing it to respond through hypertrophy. If the muscle is not allowed adequate response time, it will fail to respond properly and injury results. The skeletal system acts in much the same way. As the bones are stressed, they hypertrophy to better handle the loads, but if loaded excessively and repeatedly, they fail to hypertrophy and a stress fracture results. Gradually increasing the level of training and allowing adequate recovery time is essential if one is to prevent overuse injury. Increases in the training intensity should be restricted to approximately 10% a week or less, and a day per week of recovery is advised. Inflammation in bursa, tendons, and/or fascia are usually the result of overuse as well. Rest, ice, and aspirin are the mainstay of therapy of these inflamed tissues.

Disproportionate muscular development predisposes to injury. Running develops certain muscle groups more than others, and the runner who does not vary his training techniques or compliment his training with weight training will not build muscular strength evenly. This disproportionate development predisposes the underdeveloped muscles to injury. The groups preferentially developed are the gastroc-soleus complex, the hamstrings, and the lumbosacral paraspinous muscles. The most common group injured is the anterior leg muscles, those responsible for ankle dorsiflexion. Shin splints is the result of disproportionate strength between the gastroc-soleus complex and ankle dorsiflexors. The gastroc-soleus complex easily overcomes the weaker ankle dorsiflexors. The loss of flexibility which accompanies the gastroc-soleus complex hypertrophy contributes to this disproportionate syndrome. A similar phenomenon occurs in the lumbosacral paraspinous musculature and the abdominal musculature. Increasing strength in the lumbosacral spine produces increased lumbar lordosis and subsequently low back pain. These conditions are best prevented by a combination of weight training to build the strength of the weaker groups and flexibility exercises to prevent loss of flexibility secondary to hypertrophy of the muscles.

The third underlying cause of injury is a minor anatomical abnormality. These variations from normal most commonly occur in feet and are rarely symptomatic unless stressed. The anatomic abnormalities in the lower extremities exclusive of the feet include unequal limb lengths, increased femoral neck anteversion, lateral patella tracking and external tibial torsion. These are relatively unusual and if present are commonly amenable to therapy through alterations in footgear.

Hind foot pronation (a vulgus tilt at the subtalar joint) is the most common abnormality in the foot. The forefoot supinates to compensate for the hind foot pronation, and the patient has a diminished arch. This is not a rigid foot. Symptoms are produced by the repeated stress placed on the medial ligament and capsular structures during the running gait. A medial heel wedge allows the subtalar joint to supinate during stance phase; joint motion is more physiologic; and the stress on the medial ligament is relieved. Limited ankle dorsiflexion is a second common abnormality. Without 10° of ankle dorsiflexion, the trailing foot will be stressed to its limit of dorsiflexion with each step. The runner will be required to shorten stride length, altering the normal gait pattern. An adequate heel lift and stretching of the gastroc-soleus muscle groups should relieve these symptoms.

The effect of aerobic running on articular cartilage is unknown. There is no evidence that prolonged and repeated use of a normal joint predisposes to degenerative arthritis. It is uncommon to see a distance runner with degenerative joint disease. I do not think the risk of early degenerative joint disease should preclude aerobic running as a form of exercise to obtain physical fitness. This is if the joints are normal and asymptomatic. A joint which becomes swollen after exercise or produces pain during running should not be stressed by aerobic running. This joint is not a normal joint and repeated stress will cause permanent injury. It is clear that once a joint begins to degenerate, heavy use will accelerate the degenerative process. Exercise and the maintenance of muscular tone is beneficial to degenerative joints, but these objectives should be accomplished with minimal weight bearing. I advise my patients with degenerative joint disease to become aerobic swimmers.

Shoes are important and usually worth the money. The guiding principle is "If the sho· nits, wear it." As the level of training increases, more attention must be paid to shoes. Generally the toe box should be large; the uppers should "breathe"; and a heel wedge of 11 to 14 millimeters is adequate. Those runners with variant anatomy in their feet must purchase a shoe suited for their foot, and occasionally they need to add orthotics. When buying a new pair of running shoes, put on both shoes and walk around until you have made a decision regarding their comfort. The shoes should be comfortable initially as they should not appreciably change during their lifetime. The next word of caution is not to try and stretch extra miles out of worn shoes. This will lead to injury.

Physical fitness is the goal, and aerobic running is an excellent method of obtaining that goal. Aerobic running is fun once your system is conditioned. My advice to those who wish to start is to build slowly. Using one's heart rate as an indicator, 20 minutes every other day is the starting place. The heart rate should be kept around 120 to 130 beats per minute. Many beginners accomplish this with brisk walking, and that is fine. As one's physical condition improves, increasing the time, pace and frequency are in order. By continuing to monitor the heart rate and keeping it around 120 to 130, a smooth course will be experienced. As one's mileage increases to 35 miles a week or more, one should include stretching exercises and weight training to minimize the risk of injury. Gentle stretching prior to and following the aerobic running is beneficial. Push-ups and sit-ups are adequate weight training for the average daily runner.

When injury occurs, I recommend a reduction in the intensity and frequency of training with greater care paid to stretching. If the symptoms do not resolve in one week or if continued training at the reduced level is not associated with relief, then a thorough examination is appropriate. Recovery after an injury should be gradual, and the runner should not expect to immediately return to his pre-injury training level unless he or she also expects a recurrent injury.

As the cardiovascular system strengthens and those excess pounds melt, the runner becomes addicted—addicted to physical fitness, which in my mind is a positive addiction. If I could not run, I would seek another method to maintain my fitness.

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Preparticipation Screening Program for High School Athletes

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Metropolitan Miami, (Dade County), has 23 senior high schools engaged in interscholastic athletic activities. Each athlete is required, by law, to have a physical examination each academic year prior to sports participation. In the past several years, the public school system, in conjunction with the School of Health and Social Services, the Department of Physical Therapy at Florida International University and a group of interested physicians have provided a sports medicine clinic for the

purpose of preparticipation screening physical examinations as well as providing a weekly clinic in which the team physician, trainer and athlete can avail themselves of help in the rehabilitation and conditioning following an injury.

Before the first practice session, every potential player has a thorough physical examination including a general history which is explored for possible clues as to future physical problems. Parental or guardian permission is secured. We have insisted that the history be completed by the athlete and his parent or guardian and signed by both. In addition to providing an evaluation as to the physical capability of the athlete for participating in contact, non contact, endurance or other sports, a program of planned conditioning and other specific recommendations referable to any changes noted on physical examination are made. We have adopted the suggested disqualifying conditions for sports participation as put out by the University of Wisconsin. The male athletes were instructed to wear shorts underneath their clothes and the female athletes to either wear shorts and a halter or a two piece bathing suit. The examinations in the past were done individually at each high school for only football, but over the past several years we have utilized the physical therapy facility at Florida International University where most of the preparticipation physical examinations were done for boys and girls in all sports. The examination is carried out by stations utilizing nursing personnel, physicians, physical therapists and physical therapy students. The examination is done in stages utilizing separate rooms to evaluate the blood pressure, pulse, respirations, heart and lung, abdomen and genitalia, eye examination, height and weight, and then into a large room where the musculoskeletal examination is done. At the conclusion of the examination of each school, the history and physical examinations are reviewed by the senior physician present and any abnormalities found are discussed with the trainer and coach with instructions for conditioning exercises, referral to the family physician or local health clinic for further evaluation as needed.

In 1977 and 1978, we examined approximately 1,653 boys and girls from the ages of 14 through 18 with the predominant age group being between 15 and 17 years. We found that 1.2% had blood pressure elevations of greater than 140/90, vision defects by the Snellin chart of greater than 20/40 in ½%, many of these had already been corrected by glasses. There were four individuals with vision changes of more than 20/200 in one or both eyes during this period of examination. We found an incidence of 1.2% hernias including undescended testicles in two and absent testicle in one. We had an incidence of 8.2% scoliosis and 2% of the athletes had abnormal lumbar lordosis. The incidence of scoliosis seemed to vary from school to school. The predominant extremity problem was in the knee with an average of 14.8% of the athletes having an abnormal finding. These ranged from laxity to evidence of chondromalacia, which may or may not have been symptomatic, genu recurvatum, symptomatic Osgood-Schlatter's disease, previous knee surgery, hypermobile patella and genu varum. The next highest incidence was in ankle and foot identifiable abnormalities or possible problems in 9.2% of the athletes examined. In the upper extremity the predominant problems were related to the elbow with an incidence of 1.2% of the athletes examined having abnormal elbow examinations. It has become our feeling that in examining relatively healthy young individuals there is little apparent need for yearly re-examinations. In an attempt to define this problem we evaluated three schools in whom we had done physical examinations in two consecutive years. There were 509 athletes examined; re-examining 98 and missing five abnormalities. The missed abnormalities were scoliosis twice, a burn scar of the hand once, an old finger fracture once, and one functional cardiac murmur. This amounts to approximately 1% miss rate and none of the abnormalities missed would have interfered with the athletes participation in their sport.

We have also attempted to define arrhythmias in the high school athlete hoping that if we could define this problem we might diminish the incidence of sudden death. We have evaluated cardiac rhythm at rest, with exercise and any changes were monitored by avionics through the efforts of one of our cardiologists and his assistant. This is an ongoing study and at the present time there does not seem to be any significant yield to justify continuation of this program in its present form.

In summary, in Metropolitan Dade County there is a sports medicine program available to all high school athletes engaged in inter-scholastic sports, of which there are 22, with approximately 4,000 athletes actively participating each year. We have attempted to provide a preparticipation physical screening program which we think is of benefit in identifying problems, offering rehabilitative programs when applicable, and referral to appropriate medical sources for further evaluation and care when necessary. In addition to this, we have a continuing program of rehabilitation education and evaluation on a weekly basis at our sports medicine clinic at Florida International University.

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The War on Sloth

James F. Fixx

Strategies for Overcoming Inertia

One recent spring, just as the azaleas were starting to bloom in southeastern Missouri, a forty-three-year old surgeon named Jean Rene Dupont decided to organize a class for new runners. With the encouragement of the administrator at the Missouri Delta Community Hospital in Sikeston, Dupont, who had been running for ten years, got word of the program to his colleagues and some friends. Four women and sixteen men joined up. Because of round-the-clock schedules the whole group was seldom able to run at the same time, but whenever possible members worked out together for mutual encouragement and camaraderie. Most were soon able to cover two to three miles without stopping. Dupont was delighted. "Those runners," he told me proudly, "were as highly motivated as any group could be."

No one, including Dupont, fully understands what happened next. One member dropped out because of the pressures of his medical practice. Several others, citing the same reason, soon dropped out, too. By late summer only a dozen of the original twenty remained. "Then the bad weather came," said Dupont, "and that was it. By that time I was the only one running. I'm still running—alone." Meditating ruefully on the experience, he told me, "People will do almost anything to get out of exercising. I have been most unsuccessful in encouraging people to run."

If we lived in a properly logical world the motivational problem would not be as troublesome as it is. Most of us, after all, want to be healthy, feel good, look young and live a long time. Since even modest amounts of exercise are likely to help achieve all those ends, simply realizing that fact should be enough. But since when has reasonableness had much influence on human affairs? The mind, as we all know, is ingeniously inventive at devising excuses, and equally inventive at concealing what it is so persuasively doing. "Some people," says Lee Spade, a Columbus, Ohio, psychologist, "are genuinely self-destructive. To better their emotional and physical well-being runs counter to a deep-seated need for self-harm." Similarly, Dr. Peter O. Knight, a Florida cardiologist, told me, "During my fifteen years of medical practice I have heard practically every reason one can offer to avoid exercising. In the final analysis the majority of people have a psychological barrier that allows them to rationalize their status as being unique: that is, the preventive medical benefits of exercise are for the other guy, while they themselves are in some way not vulnerable to disease. It is just not convenient to look too closely at reality." Even dedicated runners know the siren song that beckons them to run fewer miles than they should or to run less often. How much more beguiling, therefore, is that song to a person long accustomed to the pleasures and indisputable rewards of slothful living.

I therefore started talking with people who might shed light on the question, among them doctors, coaches, YMCA and corporation fitness directors, preventive medicine specialists, and scores of ordinary runners who, in one way or another have been successful, or in some cases revealingly unsuccessful, in persuading others to exercise. Out of nearly fifty such conversations emerged, first, a vivid sense of the difficulty of the task. At the same time I caught an occasional hopeful glimpse. There are tested motivational techniques that may make it easier to embark on a running program and, once embarked, to stick with it. Most of these techniques, moreover, are equally applicable to ourselves and to those we may be trying to encourage. Significantly, too, such psychological force-feeding is usually necessary only at the start of a running program. Once a participant discovers that running isn't just hard work but fun, too, motivation pretty much takes care of itself.

Part of the inertia problem is that too many of us were taught to look on exercise as punishment, or at the very least as an activity that isn't notably pleasurable. A Roselle, New Jersey, runner named Fred Schumacher told me, "I've found that many people resist exercising because of a previous bad experience—physical education in school or physical training in the service."

The problem is compounded by the fact that exercise isn't all fun at the beginning. Muscles protest.

This is an excerpt adapted from Jim Fixx's second Book of Running, Published by Random House. Copyright by James F. Fixx.

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Fixx, a former magazine editor, has served as articles editor of **Saturday Review**, senior Editor of **Life**, and Editor-in-Chief of **McCall's**, among other posts. He is the author of numerous articles for national magazines, including **Newsweek**, **Reader's Digest**, and **Sports Illustrated**. He currently serves as a consultant to the President's Council on Physical Fitness and Sports.

Lungs burn. The next morning you feel creaky and sore. Nor, usually, do you improve as quickly as you'd like. "The beginning is the most difficult," says Schumacher. "The rewards are almost nonexistent and the sacrifice required is measurable."

For all these reasons, persuading yourself or anyone else to start running is seldom easy. I spoke, in fact, with only one person, a cardiologist, who claimed never to have experienced any difficulty. "I tell my patients," he said dryly, "that if they don't change their way of life they're going to need a coronary bypass operation. When they start thinking about having someone cut into their heart, they're anxious to take steps to avoid it." Most of us, however, are not jolted quite that arrestingly into a sense of the urgency of exercise. Truth to tell, we probably feel fairly good without it; it is only our puffing with exertion and the girth of our waistlines that suggest that all may not be entirely well within. We realize, therefore, that if we are going to be moved to start running, we are probably going to have to do most of the moving ourselves; no obliging cheerleader will come along to prod us into it. Dr. Art Mollen, a Phoenix preventive medicine specialist and a tirelessly articulate champion of running, writes in *Run for Your Life*, "Beyond a few tests and some prescriptive advice, there is really nothing I can do to you or for you. If anything happens, it will be because you will do it to and for yourself."

Dr. Max L. Irick, a Missouri physician, told me, "I have found that encouraging people to exercise when they have not expressed the desire to is generally useless. It has been my experience that the average individual needs a source of inspiration more than a source of information."

If, however, the sources of motivation lie within, so, of course, does motivation's opposite, the mechanism that generates excuses. Excuses are, in fact, so indigenous a part of exercise that Mollen devotes a whole chapter to them.

Most professional physical fitness specialists, having searched in vain for a single technique that will motivate everybody, have reluctantly concluded that there probably is no such key. About all you can do, says Seth Chavez, who conducts adult fitness classes in Massachusetts, is instill confidence, create a pleasant atmosphere and have an understanding attitude. Maureen Bike, a women's fitness leader at the Fairfield, Connecticut, YMCA, says it is the obvious physical rewards that most often do the trick. Women, she points out, typically lose 1.5 percent of their body fat within the first eight weeks. "Such concrete evidence of success is usually all they need to continue."

Bribery. Some time ago Jess A. Bell, who heads the Bonne Bell cosmetics firm, decided he wanted to encourage his employees to exercise more. A practical man, Bell devised what seemed to him a straightforward scheme. He offered a dollar for every mile run, fifty cents for each mile walked, and twenty-five cents for each mile covered on a bicycle. The program succeeded so well that, paradoxically, Bell was forced to rate it ar utter failure. "We ran out of money," he says with dismay. "There were people running 200 and 250 miles a month. They obviously weren't out selling—they were out running. So we had to give that up."

Exaggeration. Partisans of running do a clear disservice to their cause when they call it a religion, argue in the face of the best medical evidence that it is a sure preventative of heart attack, and insist that runners stay young forever.

Overregimentation. One of the pleasures of running is that we're able to do it at our own pace. When a running program is so rigidly prescribed that it becomes overregimented, it is prima facie self-contradictory and interest in it is almost sure to fall off.

Overwork. Encouraged by weight loss, new energy and the pleasure of getting back into shape, some beginners try to do too much too quickly.

Hypocrisy. Annette P. Sadowski of Detroit works for an endocrinologist named Charles P. Lucas. One day Lucas, a marathon runner, asked her, "When are you going to start running?" Her reply was prompt and unambiguous: "When hell freezes over." Lucas, a wily and patient man, bided his time. Finally, one brisk October day, he invited her to come along with him to a marathon. Though still skeptical of the whole sweaty enterprise, Ms. Sadowski agreed to go. "It was the first time I had seen anybody run just to run," she said later. "I still thought Dr. Lucas was crazy, but suddenly it was an acceptable form of craziness. I loved the excitement of the race and found myself seriously considering becoming a runner." Not long afterward she laced on her first pair of running shoes.

If, despite good examples and excellent intentions, you nonetheless have trouble staying with a running program, it may be comforting to know that even experienced runners run afoul of the problem. Fatigue, an overcrowded appointment book, travel or any of a hundred other reasons can make it seem impossible to exercise. The answer at such times is to counterbalance excuses with reasons for running persuasive enough to pry ourselves out of our inertia. The authorities I spoke with cited a number of weapons that have proved useful:

Understand What Exercise Does. Dr. Joseph Arends of Troy, Michigan, points out that while most of us are convinced we ought to exercise, few of us know precisely what exercise does. "The vast majority of people," he says, "do not understand the physiological, biochemical and personality changes that occur with endurance conditioning. Only when they understand these changes can they find any reason to maintain the

life style we desire. Before you can motivate you must educate."

Make a Mental Commitment. Earlier in this chapter I mentioned the instructive case of Walter Guzzardi, who years ago pledged to run every day and doggedly kept his promise. If, like Guzzardi, you take promises seriously, making a serious commitment to an exercise program may be all that's required.

Acknowledge Running's Disadvantages. Many people, having been called to running by promises of painless, instantaneous miracles, become discouraged when they find that much of the time it's just plain hard work. Try, therefore, to remember that, as Maureen Bike puts it, "there are no shortcuts to fitness—you've got to work at it." Similarly, Terence Kavanagh told me. "The potential exerciser, whether jogger, cross-country skier, swimmer or what have you, has to be educated into not only the advantages but also the disadvantages of the hobby. It is pointless to expound over and over the 'highs' of exercise without preparing the novice for the day-to-day aggravations, even the more serious hazards. If you con someone into an exercise program with promises of instant euphoria (or even immortality), then don't be disappointed if he or she becomes discouraged when the first three months result in sore muscles, aching joints and stories from sedentary neighbors about the guy from the office who dropped dead jogging."

Identify Your Own Stumbling Blocks. Make an honest list of the reasons you find it difficult to run. Then try to overcome each objection.

Nothing is more discouraging to a twentieth-century human being, happily immersed in life's sedentary luxuries, than to be told he or she should abandon smoking, drinking, overeating and the other pleasures and marvels of the flesh. To do so seems pure deprivation, with little if anything in return. If, on the other hand, we make changes in order to go toward good health, then the deprivations are likely to seem minor by comparison. When, a dozen years ago, I weighed 214 pounds, a daily fullcourse lunch seemed important. Today I enjoy food no less, but I'd rather have a good afternoon run than stuff myself at lunchtime.

Exercise According to Need. Sometimes I think my marathoning friends and I must be an appalling and alarming sight to a novice runner, venturing out as we do every day to run ten or more miles. Novices, and for that matter everybody else, should remember, however, that it's not necessary to run nearly that much. As Dr. Ralph Paffenbarger has convincingly demonstrated, a mere half-hour a day is enough to confer a satisfactory degree of fitness. Running more than that is perfectly all right if you're in serious training or if you simply enjoy doing it, but it is hardly essential.

Set Goals. Then Periodically Evaluate Your Progress. Goals can be as idiosyncratically individual as we like. An adventurous Michigan runner named Sarah R. Weber made a Xerox copy of a county map and set out to run on as many of its roads as she could. Every time she ran on a new one she colored it yellow. Bridges were a special treat for Ms. Weber. "I confess a personal addiction to bridges," she told me. "Running over bridges is the most delightful running I know. I collect bridges and share them with my favorite fellow runners." Bud Getchell says it's fine for goals to be modest—perhaps to complete a five-mile race six months from now—but it's important to have them. "Without a plan based on goals," Getchell wrote recently in Ball State University's *Adult Fitness Program Newsletter*, "it is very easy to find some excuse to miss a day or more of training."

Insist on Making Time for Running. You're not likely to have success with a running program unless you give it high priority. An overweight friend of mine, having decided he ought to lose weight, told me he planned to run "whenever I can find the time." It was no surprise to me that he quickly sank back into his old ways. "If individuals can get into the habit of starting workouts at a certain time every day, they will accept them as part of the regular daily schedule," Franklin points out. "Exercise will become habitual and the day won't seem complete without it." An increasing number of people, eager to exercise and at the same time save gasoline, have taken to running to and from work. A Boston physician, Arthur J. Siegel, has even coined a word for this form of commuting: *jogamuting*. "With the energy crunch," Siegel told me, "this approach seems even more relevant than ever."

Run with Others. Running with other people can be a powerful reinforcement to good intentions. "I encourage beginning runners to associate themselves with a Road Runners Club chapter or a jogging group," says Fred Schumacher. "Associating with people who have experienced what we are going through is an inspirational experience and serves to increase self-discipline."

Remember that Running Is Fun. In our concern with losing weight and becoming healthier, it's all too easy to allow ourselves to be preoccupied with the physical changes running produces and to forget that running is a pleasurable activity, its effects aside. "When health is the only motivation," a sixty-year-old Florida runner named Al Iannone said, "great self-discipline is needed." If we run for the fun that's in it, fitness will take care of itself. Terry Masto told me, "I try to show my students that exercising is fun and feels good."

For most runners, such persuasive techniques and psychological ruses as I have been describing are necessary only at the beginning. It is part of the peculiar magic of the human mind and body that once set on the right course, however artificially, they tend to remain on course. As you first turn to running, therefore, you may find you have to lure yourself with feigned enthusiasms

and temporary stratagems. Inevitably, however, your internal gyroscopes will take over. At that point you will find yourself irresistibly wanting to run. As I write these lines I have been at my typewriter most of a sunny spring day. From my window, through a halo of elm and oak leaves, I have seen several runners pass. Watching, I have wished myself with them but have waited, preferring to run as a reward rather than as an indulgence. Now, having written to the end of this chapter, I feel freed to lace on my running shoes and go. For me, running is not something I must do but something I want to do—pure, joyful play. No matter how difficult or unpalatable you now find running, it will become that way for you too, that's a promise.

• Mr. Fixx, 37 Crescent Road, Riverside, Connecticut 06878.

Wellness: The Living Option

John Fidler

The American way of life may be hazardous to your health or, said another way, the good life can kill you. For the most part, Americans are choosing the way in which they die. Bad habits, like smoking, eating rich foods and no exercise, contribute to three-quarters of the deaths in America each year.

Generally speaking, bad living habits have replaced infectious diseases as the big killers in our society. In HEALTHY PEOPLE, the Surgeon General's report on health promotion and disease prevention, it states: "Americans are killing themselves needlessly by smoking, drinking, poor diet and preventable accidents . . . Currently only two percent of the healthcare dollar goes toward prevention." A true health revolution would mean a long overdue choosing of new priorities for all Americans.

Physicians have always been experts in finding causes of diseases. Medical technology has made America the place to be if you are sick; however, America is not necessarily the best place to be if you are healthy. Physicians are prepared to cure the ill patient but what about the education of those who are still healthy?

Apparently there are few incentives for physicians to enter the realm of preventative medicine. Third party payers of health insurance do not encourage house calls or prevention visits to the doctor; few health or life insurance companies offer discounts for those who chose healthy lifestyles; pharmaceutical companies, whether in using movie stars to sell antacids on TV or in promoting thousands of prescription drugs to physicians, don't seem to have heard of the word "prevention." It's easier to hand the patients pills rather than discussing their problem.

Although patients turn to doctors when they are sick, too frequently they turn to non-health professionals for advice on how to maintain their health.

If this trend is to be reversed, physicians, hospitals and health professionals must unite their efforts, not only in combating illness and disease, but also in the prevention of disease and the preservation of health.

In an effort to promote physical, mental and spiritual health among its employees and physicians (and eventually the community), Imperial Point Medical Center, Ft. Lauderdale established the Well-Care Program. The program was developed by the medical center's medical and administrative staffs through their interest in preventive medicine, physical conditioning and more effective utilization of hospital services. Assistance came from the Be-Well Project, which is funded by the local American Heart Association to aid local organizations interested in developing health promotion programs, and from the Office of Health Promotion and Information. Department of HEW, which designated Broward County as one of 18 communities nationwide to receive technical assistance in the development of a model health program.

Initially, the Well-Care Program consists of a sample group of 100 employees. The program begins with an orientation session where participants get to meet each other and learn about life habits and their effects on

The Author

JOHN FIDLER

Mr. Fidler is Administrator of Imperial Point Hospital, Fort Lauderdale.

personal well-being. Participants complete a confidential, computerized health questionnaire (Health Risk Appraisal) which asks questions about personal health data, family history and lifestyle customs.

In the second stage, participants undergo a health screening process in which laboratory and non-laboratory measurements are collected, including cholesterol level, blood pressure, height, skin-fold measurements, cardiac stress testing and cardiopulmonary evaluations.

In the third phase, participants receive a computerized risk profile which includes results from their questionnaire and laboratory measurements. At that point, they meet one-to-one with a physician and a trained wellness counselor to develop a prescription for changes in their lifestyle.

The fourth step is a series of programs to help individuals learn skills in achieving "self-directed change." Currently, we are offering programs in nutrition and weight reduction; physical fitness and rehabilitation programs geared to improve cardiovascular fitness and increase respiratory endurance; smoking cessation; and stress modification and reduction programs.

Self-responsibility is the foundation of the Well-Care Program at Imperial Point Medical Center. Without it, commitment to any of the aspects of wellness is difficult. It's directed towards lifestyle modifications as an avenue of preventive medicine. Physical fitness alone is not enough; however, it can be a cornerstone of a wellness program.

No single element addresses the causes of the many chronic diseases that afflict Americans today. Therefore, the Well-Care Program emphasizes all aspects of environmental modification to make the hospital surroundings a more healthy setting within which to work. The medical center's entire nutritional program has been revamped with the cafeteria now offering nutritional choices more homogeneous with a natural lifestyle. Employees are encouraged to use the stairs and take alternative physical fitness breaks. No cigarettes are sold on the hospital grounds and techniques of stress reduction are being taught.

It is felt that the Well-Care Program works to bridge the gap between traditional medicine and the wellness approach to health. It enables Imperial Point Medical Center to respond to the needs of all individuals, whether they be sick or well.

As an added benefit, the Well-Care Program represents an effort in cost containment with the reduction of expensive medical intervention to preserve one's health. The information and programs developed at Imperial Point will serve as a community resource in the development of other wellness oriented lifestyle programs.

Despite the efforts of the North Broward Hospital District, the taxing district to which Imperial Point Medical Center belongs, to create quality hospital care, significant numbers of persons have continued to recycle into the acute care setting. As one of the first hospitals in the country to embark on a comprehensive wellness program, Imperial Point is redefining the role of the hospital as a health resource with an interest in broader health applications.

Physicians and hospitals should examine what they are doing to promote the health and quality of life of their patients, employees and citizens within their service area. Are we promoting illness and dependency or are we promoting wellness and educated self-responsibility for health? Shouldn't your healthcare programs include wellness, the LIVING OPTION?

Don't Dive and Fly

Divers who subsequently fly run the risk of bends, according to an article in the January 12, 1980 issue of "FLIGHT International". Prominent British aviation Dr. Ian Perry reported these facts during the 50th anniversary meeting in Washington of the Aerospace Medical Association. Dr. Perry commented on a case of an airline passenger who had previously been diving to a depth of only 100 feet. Over the next 24 hours he suffered severe spinal cord "bends" and was treated in a compression chamber.

Dr. Perry warns that bends are more likely to occur if you drink or smoke too much. They can occur at 15,000 to 18,000 feet. If you have been diving, bends can occur if you fly as low as 1,000 feet. Commercial airliners fly with a cabin altitude simulated at 4,000 to 8,000 feet.

Our thanks to an alert Dr. Tom Jenkins of the ECMS who pointed out this article to us.

Florida Governor's Council on Physical Fitness and Sports

James J. Carnes

The strength of a nation is measured by the health and vitality of its citizens; therefore, an important function of government is to encourage and support participation in sports and physical fitness activity by persons of all ages. The Florida Governor's Council on Physical Fitness and Sports functions to promote physical fitness and sports for the general populous of Florida.

In carrying out its responsibilities, the Council acts as a catalyst, cooperating with schools, colleges, clubs, industry, recreation and health service agencies, sports governing bodies, health professionals and federal, state and local agencies in matters pertaining to physical fitness and sports. The Council, acting in an advisory capacity to the Governor and his staff, recommends programs for stimulating interest and involvement in fitness and sports activities. (Sports For All—Position Paper; Alexander and Crider, 1979.)

History of the Council: In May, 1977, Fran Carlton, a freshman legislator from Orlando, stood on the floor of the Florida House of Representatives and explained her concerns about the physical condition and health of Floridians. She pointed out that 50% of all Americans are overweight and that over 55% of them will die from diseases associated with obesity and lack of physical activity. Enough Representatives and ultimately Senators listened and became concerned. They examined the recommendations from an earlier appointed Task Force on Physical Fitness and passed a bill creating the Florida Governor's Council on Physical Fitness.

In 1979, Pete Skinner, a senator from Lake City, formulated plans to create a Sunshine State Commission on Sports to promote amateur and professional athletic activities and organize the Sunshine State Games. This was presented in bill form to the Senate by Senator Skinner and to the House by Representatives Sam Bell (Daytona Beach) and Fran Carlton. The final outcome was an amendment to the original bill. Sports was then added to the Council's name, thereby making it the Governor's Council on Physical Fitness and Sports. This Council is charged with the power and duty to develop, foster, and coordinate services and programs for physical fitness and sports for the people of Florida.

In July of 1979, Jimmy Carnes was appointed by Governor Bob Graham as the Executive Director of the Council, and there are five full time staff members working to carry out its duties. They are Max Clark, Deputy Executive Director; Judy Anderson, Physical Fitness Coordinator; Mary Cromer, Public Relations Coordinator; Doug Hill, Special Events Coordinator; and Dara Houliston, Secretary. There is also a twenty-five member advisory council selected from various professions and interest groups involved with physical fitness and sports. This group meets semiannually with the staff members to formulate the direction the Council will take in promoting physical fitness and sports throughout Florida.

Council Projects: Since beginning work in August, the Council staff has been actively involved in a wide variety of projects. These include:

Sunshine State Games: This will be the first year for the Sunshine State Games, which were established under Senate Bill 119, sponsored by Senator Pete Skinner. These Games are designed to be a mini-Olympics for the State of Florida. Competition is for amateur athletes and will be patterned after the Olympic program. The 1980 Games will be held in July and August in Gainesville, Florida.

The Sunshine State Games were developed for the residents of Florida to promote amateur athletics in the State. Through these Games, we hope to encourage wholesome athletic competition and foster incentive for the improvement of relations between the young and the old.

The Author

JAMES J. CARNES

Mr. Carnes is Executive Director of the Governor's Council on Physical Fitness and Sports, National AAU Chairman for Men's Track and Field, President of Athletics Congress of the U.S.A., and Head Coach for the 1980 U.S. Olympic Team in Track and Field.

Sports committees have been set-up and are comprised of persons involved in age group, high school, and collegiate/open activities for their sport. These committees will be responsible for promoting and improving their particular sport within the State of Florida.

Physical Fitness for Senior Citizens: Just because one has reached the retirement age does not mean it is time to slow down and do less. It is important for one to stay active and keep fit in order to enjoy good health. Because of this, the Governor's Council is currently researching and studying physical fitness programs for senior citizens from around the country in an effort to establish a program for our State. Florida's program will be devised and set-up to reach all levels of achievers, so that all may benefit from participating in the program. A Senior Citizens Advisory Committee will be formed to assist the Council in its endeavors and to offer recommendations on the needs of senior citizens.

Local Councils on Physical Fitness and Sports: In order for the Governor's Council on Physical Fitness and Sports to be effective in reaching its goals, the cooperation of the entire State is a vital necessity. To help develop such cooperation and leadership, the Council has suggested that major cities throughout the State establish their own physical fitness and sports council. Response, thus far, has been favorable and guidelines are now being established for those wishing to establish a local council. Constant communication with these councils will take place, and we will offer suggestions and technical advice on establishing programs in their communities.

Bidding for National Events: The Council is interested in seeing that Florida is chosen as the site of as many national sports competitions as is possible, because of the economic impact they can have on the various industrial and developmental factions of the State. Staff members will assist cities and institutions wishing to bid for a national event in any sport. To date, the Council has been involved with a number of such projects including the 1981 National Sports Festival (Orlando), the Olympic Trials for Rowing (Tampa), the Olympic Trials for Gymnastics (Jacksonville), the Olympic Trials for Boxing (Florida), the 1981 Boxing Junior Olympics (Orlando), and the 4th World Championship for Aquatic Sports (Orlando). Assistance has also been provided to various cities preparing expansion bids for professional teams in baseball, basketball, football, and soccer. Though we cannot guarantee success in securing these bids the first time round, valuable experience is gained by those initiating these bids and governing bodies become aware of Florida's interest in hosting such events.

Proper facilities are usually a prime factor in securing a national event. Since such facilities are lacking in some sports, we are looking for ways to finance the building of new facilities and the improvement of already existing facilities. We have surveyed the facilities in the State in order to determine what is needed in each area.

Bicycling: In the fall of 1979, Linda Crider, the former director of physical fitness for the Governor's Council, served as chairperson of the Governor's Bicycling Activities Advisory Committee. This group studied the status of bicycling in the State and made recommendations for the promotion of the use of the bicycle as a significant mode of transportation. One of the committee's key recommendations for implementing the Florida Bicycle Program was the recommendation to appoint a bicycle coordinator who would be responsible for the administration of the program. The Council will continue to keep tabs on this program and offer assistance and advice when needed.

Other programs handled by the Council deal with recognizing persons or groups for outstanding contributions and/or achievements in physical fitness and sports; providing names of speakers to persons requesting a speaker for their various meetings; and endorsement of projects and events that promote physical fitness and sports throughout the State.

It is an exciting time in the United States and the State of Florida for physical fitness and sports and the Governor's Council on Physical Fitness and Sports looks forward to coming up with many innovative programs that would make Florida a leader in providing opportunities for participation by the citizens of our State.

• Mr. Carnes, Office of the Governor, State of Florida, The Capital, Tallahassee 32301.

MARK THESE DATES ON YOUR CALENDAR...
MAY 7-11, 1980
106TH ANNUAL MEETING OF THE FLORIDA MEDICAL ASSOCIATION, INC.
DIPLOMAT HOTEL, HOLLYWOOD-BY-THE-SEA

Summary: Of Cabbages and Kings

James B. Perry, M.D.

As a positive life style pattern for the 80's has emerged, the membership of the Florida Medical Association embarked on an ambitious program to investigate and implement a program of physical fitness. It is with great humility and honor that the editors of *The Journal* and the myriad of people who implemented the undertaking, at first grudgingly, and then incredulously, began to unravel the true meaning of fitness as a portion of a positive life style.

The tackling of the causes of early death over the centuries has led us into verdant and fertile pastures of medical research. At first shamanism followed by naturopathy and finally investigative research have caused the destruction of many myths.

Sound scientific methods and principles were implemented and as a result longevity tables were reconstructed in the first several decades of the twentieth century. We have seen improvement in the care of metabolic, endocrinologic, infectious and cardiovascular disease than even a few months ago we would consider impossible.

Diagnostic techniques of ultrasound, computerized tomography and radiologic techniques are accelerating faster than human comprehension and budgets can assimilate. Techniques and newer developments of prosthetic devices are projected beyond the realm and scope of human investigation of only a few years ago. New fields to conquer are always there and are obvious, especially in brain biochemistry; the metabolism and insidious destruction of slow virus diseases; and the multitudinous effects and causes of neoplastic diseases. We are on the threshold of answers and we are seeing them in the sphere of physical fitness. Assuming that in good time and with the wise appropriation of facilities and funds these enigmas of disease will be controlled we must take a long good hard look at ourselves.

The Author

JAMES B. PERRY, M.D.

Dr. Perry is a practicing Neurologist in Fort Lauderdale. He is Chairman of the FMA Committee on Physical Fitness, Guest Editor of this issue of The Journal, and Vice Speaker of the FMA House of Delegates.

I suppose that in some ways we are becoming narcissistic. We love ourselves, our life style, our own beings. We also feel somewhat deified to the extent that the proverbial fountain of youth is often sought and is perhaps an impossible dream. There are, however, a number of people living to an age of well past the century mark. They are alert, happy and productive, well passed "prime". It is apparent that this age is now moving further and further toward the 80th year. What have these people done? What are they doing that can hope to promote this life pattern? Is it the belief of many that implementation of some programs as outlined in the succeeding pages of this journal could be a guide toward the goal of fitness beyond the 50's. I suppose that in America and the rest of the world, convenience; making things easier; quickness to effect the head long surge to the next year; have in a way inhibited our willingness and ability to take the time to be fit. Our leisure, taken too literally perhaps, has been a scrouge in the development of degenerative disease and atherosclerosis. Some of these problems may well be genetic, hereditary or just geriatric caused by the conquering of diseases that killed off thousands at a much younger age, just a few generations ago. Can we now conquer through our own fitness these degenerations inherent in a relatively premature aging population? Can we conquer the problems of heart disease, atherosclerosis, obesity and premature senility by making our minds as well as our bodies physically fit? In many of the articles presented it would seem that this is very probable. The vegetating that leads to retirement at sixty-five or even seventy is probably more harmful than working actively to the 7th or 8th decade. Although we do not have statistics about the majority of the people it seems that many of the giants of history worked very hard, lead relatively fruitful lives, and used and exercised body and mind through activity and mental productivity well beyond expected years. Franklin, Churchill, Einstein, MacArthur and Mao Tse-tung are a few examples of this. We see it daily in church and political leaders the world over. Some of the world's elder statesmen, religious leaders and superior court judges, as well as a number of writers and just plain laborers prove that a physicially active body and an inquisitive mind may be partially responsible for retarding organic brain syndromes or senility. Perhaps, however, it is also other factors working in these people that allow them to do this as they

seem to reach an older age without obvious stigmata or side effects of degenerative processes.

Speculation obviously works in many directions. Perhaps some of the basic research on aging and fitness will give concrete clues and answers to these piercing questions. It would seem that the door is open for additional basic research into neurohumeral, neurochemistry, as well as biochemical investigations on an ultramicroscopic level. We need to determine the effects of exercise, food and nutrition, enzyme interaction and the efforts of numerous other factors. On muscle physiology, circulatory profusion, endocrine control and integrating networks as they effect the whole unit.

In this way we may have insight into the beginning of an unlimited useful life and health. Admittedly, this is a basic and simplistic approach, but it is hoped that our emphasis on fitness will stimulate inquisitiveness into what could be a whole area of productive investigation.

From a less altruistic standpoint, it cannot help but be noted that an obviously fit person is less likely to succumb to disease or minor illnesses and be more emotionally fit to conquer the pressures of the ensuing decade. In a time of inflation and economic upheaval the less time lost and the fewer finances expended on health care the better any individual will obviously be.

In the decade of the 80's will we be cabbages or kings?

• Dr. Perry, 300 Southeast 17th Street, Fort Lauderdale 33316.

AMJA MEMBERSHIP APPLICATION

I hereby apply for membership in the American Medical Joggers Association and enclosed $25 membership dues for one year. (Medical students, interns and residents $20 per year. Canadian memberships make payable in U.S. Funds. Foreign add $6 per year) , Fill out enclosed application and return to A.M.J.A., P.O. Box 4704, North Hollywood, CA 91607. PLEASE PRINT OR TYPE

NAME_____PHONE_____

ADDRESS_____

CITY_____STATE or COUNTRY_____ZIP_____

BIRTHDATE_____ MEDICAL SPECIALTY_____

WEIGHT_____HEICHT_____SHIRT SIZE (100% cotton) S M L XL (circle)

SMOKINC HISTORY ( ) Yes ( ) No ( ) Past/Amount_____How quit_____

DO YOU DRINK ( ) Yes ( ) No; If yes, amount weekly_____

CATECORY APPLYING FOR (See below)_____

Category I -- PROFESSIONAL	Category II -- ASSOCIATE	Category III -- PATRON
Doctors (MD, DDS, DPM, DO, DVM) Doctorates (Active in sports medicine only) Registered Nurses (Active in sports medicine only)	Licensed health professionals or those with master's degree working in or doing research in sports medicine or students in professional membership category. (RD, RPT, ORT, MPH, Physical Educator)	All others who support the AMJA and are inelligible to join under professional or associate membership category, includes family members

WHEN DID YOU START RUNNING?_____WHY DO YOU RUN_____

_____

AVERAGE MILES PER WEEK_____

REASON FOR JOINING AMJA_____

_____

MEDICAL EDUCATION (include degree)_____

_____

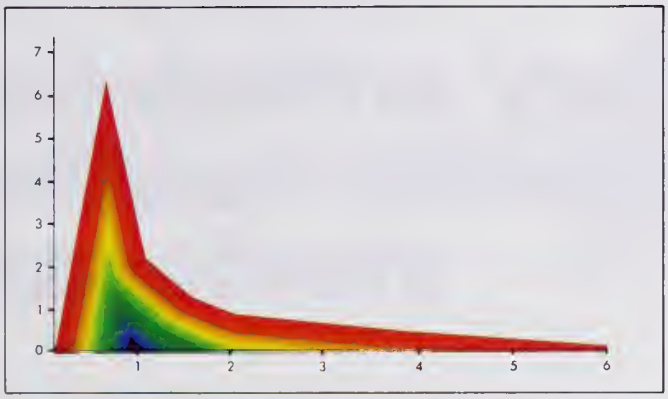
WHAT PORTION OF YOUR PRACTICE, IF ANY,IS DEVOTED TO SPORTS INJURIES?_____
DO YOU HAVE ANY OBJECTION TO BEING INCLUDED IN AN AMJA REFERRAL PROCRAM?_____
If no, please list address and/or phone that can be used for referral purposes.

_____

Membership includes: Membership card; membership decal; lapel pin; membership t-shirt; quarterly AMJA Newsletter; Information and referral service; accesss to medical data and pertinent papers on jogging which are frequently published in the Newsletter; tax deductible travel in connection with AMJA meetings; CME credits with most AMJA meetings.

SIGNATURE_____DATE_____

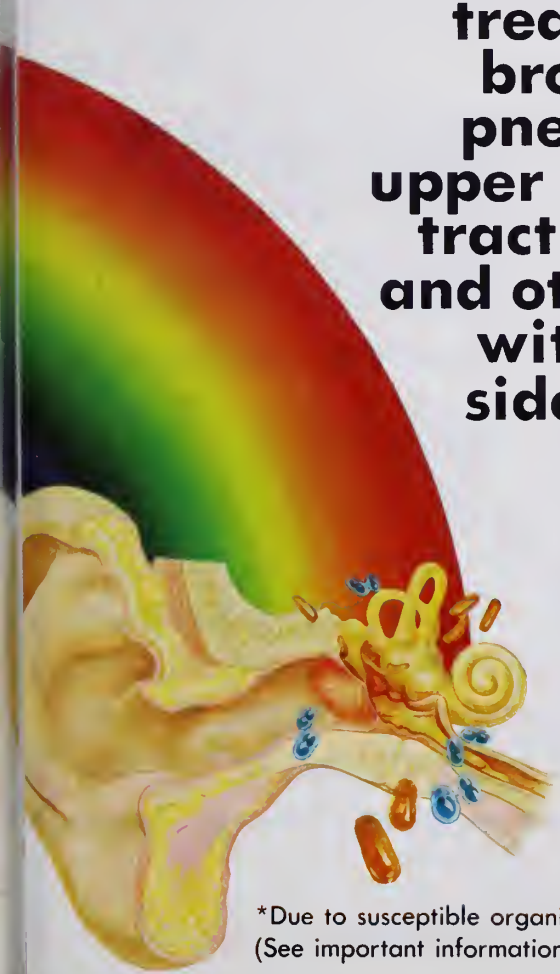
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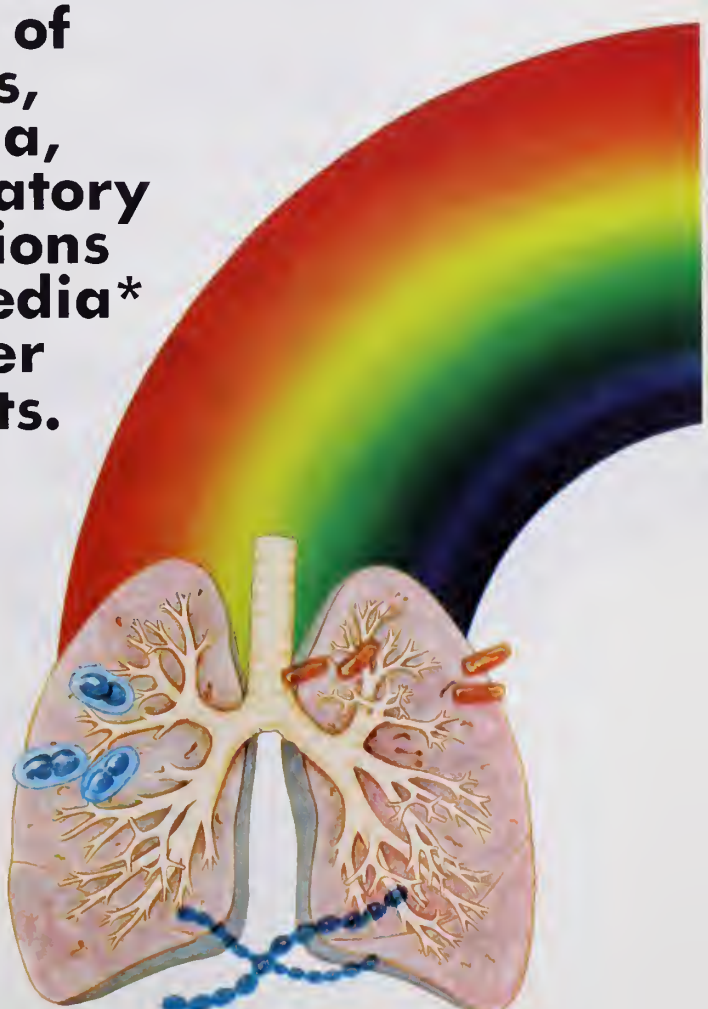


New CYCLAPEN®

(cyclacillin) Tablets/ Suspension

Efficacy proven in the treatment of bronchitis, pneumonia, upper respiratory tract infections and otitis media* with fewer side effects.





*Due to susceptible organisms
(See important information on last page.)

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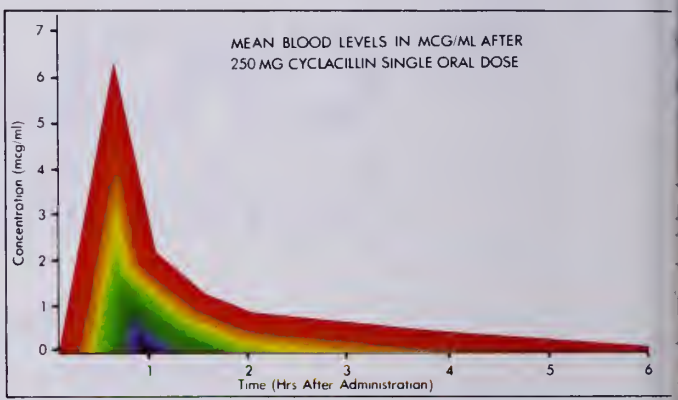
efficacy with fewer side
ampicillin confirmed in
studies of 2,58

Rapid, virtually complete absorption from GI tract

Rapid onset of action—mean peak serum levels within 30 minutes

Exceptionally high peak blood levels—3 times greater than ampicillin (clinical efficacy may not always correlate with blood levels)

Rapidly excreted unchanged in the urine—1½ times faster than ampicillin



High cure rate with CYCLAPEN®		
Causative Organism	Bronchitis/Pneumonia†	No. of Patients
S. pneumoniae	100 / 95	73
Chronic Bronchitis† (acute exacerbation)		
H. influenzae	92	12
	Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H influenzae*	
Streptococcal Sore Throat†		
Group A beta-hemolytic Streptococcus	100 / 86	44
	% Clinical Response / % Bacterial Eradication	



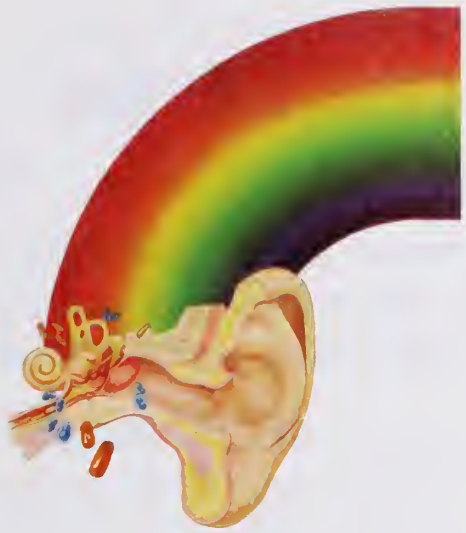
more than just spectru
in bronchitis, pneumoni
and upper respiratory tract infections†

*Includes all patients treated. 2,415 evaluated for safety; 1,819 evaluated for efficacy.

†Due to susceptible organisms.

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effects than double-blind patients*



Fewer side effects with CYCLAPEN® in double-blind studies to date[1,2]

Total number of drug-related side effects in all patients	
CYCLAPEN®	128 of 1,286 (10%) of patients
ampicillin	202 of 1,129 (18%) of patients
Difference statistically significant ($P < 0.001$)	

more than just spectrum in otitis media

Clinical efficacy of CYCLAPEN® in otitis media†

Causative Organism		No. of Patients
S. pneumoniae	96 % Clinical Response; 95 % Bacterial Eradication	82
H. influenzae	88 % Clinical Response; 85 % Bacterial Eradication	96

CYCLAPEN® (cyclacillin)
Effective for bronchitis, pneumonia, and upper respiratory tract infections†

- Excellent clinical results in bronchitis, pneumonia and upper respiratory tract infections
- Significantly lower incidence of diarrhea and skin rash

Gold JA, Hegarty CP, Deitch MW, Walker BR: Double-blind clinical trials of oral cyclacillin and ampicillin, *Antimicrob Ag Chemother* 15:55-58, (Jan.) 1979.

†Data on file, Wyeth Laboratories.

more than just spectrum

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(See important information on next page)

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more than just spectrum in bronchitis, pneumonia, upper respiratory tract infections and otitis media*

- Rapid, virtually complete absorption from GI tract
- Rapid onset of action—mean peak serum levels within 30 minutes
- Exceptionally high peak blood levels—3 times greater than ampicillin (clinical efficacy may not always correlate with blood levels)
- Rapidly excreted unchanged in the urine—1½ times faster than ampicillin
- Significantly fewer episodes of diarrhea and skin rash than reported with ampicillin in studies to date
- Excellent clinical response and outstanding bacterial eradication documented in double-blind studies involving 2,581 patients
- New CYCLAPEN® Suspension—great-tasting raspberry punch flavor

*Due to susceptible organisms.

How Supplied

CYCLAPEN® (cyclacillin) tablets:
250 mg scored tablets
500 mg scored tablets

CYCLAPEN® (cyclacillin) for oral suspension
125 mg per 5 ml:
100 ml and 200 ml bottles
250 mg per 5 ml:
100 ml and 200 ml bottles

Indications

Cyclapen® (cyclacillin) has less in vitro activity than other drugs in the ampicillin class of antibiotics and its use should be confined to the indications listed below.

Cyclapen® is indicated for the treatment of the following infections:

RESPIRATORY TRACT
Tonsillitis and pharyngitis caused by Group A beta-hemolytic streptococci
Bronchitis and pneumonia caused by *S. pneumoniae* (formerly *D. pneumoniae*)
Otitis Media caused by *S. pneumoniae* (formerly *D. pneumoniae*) and *H. influenzae*
Acute exacerbation of chronic bronchitis caused by *H. influenzae**
*Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzae*.

SKIN AND SKIN STRUCTURES (integumentary) infections caused by Group A beta-hemolytic streptococci and staphylococci, non-penicillinase producers

URINARY TRACT INFECTIONS caused by *E. coli* and *P. mirabilis*. (This drug should not be used in any infections caused by *E. coli* and *P. mirabilis* other than urinary tract infections.)

NOTE: Cultures and susceptibility tests should be performed initially and during treatment to monitor the effectiveness of therapy and the susceptibility of bacteria. Therapy may be instituted prior to the results of sensitivity testing.

Contraindications

The use of this drug is contraindicated in individuals with a history of an allergic reaction to penicillins.

Warnings

CYCLACILLIN SHOULD ONLY BE PRESCRIBED FOR THE INDICATIONS LISTED IN THIS INSERT.

CYCLACILLIN HAS LESS *IN VITRO* ACTIVITY THAN OTHER DRUGS OF THE AMPICILLIN CLASS ANTIBIOTICS. HOWEVER, CLINICAL TRIALS HAVE DEMONSTRATED THAT IT IS EFFICACIOUS FOR THE RECOMMENDED INDICATIONS.

SERIOUS AND OCCASIONAL FATAL HYPERSENSITIVITY (ANAPHYLACTOID) REACTIONS HAVE BEEN REPORTED IN PATIENTS RECEIVING PENICILLIN.

ALTHOUGH ANAPHYLAXIS IS MORE FREQUENT FOLLOWING PARENTERAL ADMINISTRATION, IT HAS OCCURRED IN PATIENTS ON ORAL PENICILLINS. THESE REACTIONS ARE MORE APT TO OCCUR IN INDIVIDUALS WITH A HISTORY OF SENSITIVITY TO MULTIPLE ALLERGENS. THERE ARE REPORTS OF PATIENTS WITH A HISTORY OF PENICILLIN HYPERSENSITIVITY REACTIONS WHO EXPERIENCED SEVERE HYPERSENSITIVITY REACTIONS WHEN TREATED WITH A CEPHALOSPORIN. BEFORE THERAPY WITH A PENICILLIN, CAREFUL INQUIRY SHOULD BE MADE ABOUT PREVIOUS HYPERSENSITIVITY REACTIONS TO PENICILLINS, CEPHALOSPORINS, AND OTHER ALLERGENS. IF AN ALLERGIC REACTION OCCURS, THE DRUG SHOULD BE DISCONTINUED AND APPROPRIATE THERAPY SHOULD BE INITIATED. SERIOUS ANAPHYLACTOID REACTIONS REQUIRE IMMEDIATE EMERGENCY TREATMENT WITH EPINEPHRINE, OXYGEN, INTRAVENOUS STEROIDS, AIRWAY MANAGEMENT, INCLUDING INTUBATION, SHOULD ALSO BE ADMINISTERED AS INDICATED.

Precautions

Prolonged use of antibiotics may promote the overgrowth of nonsusceptible organisms. If superinfection occurs during therapy, appropriate measures should be taken.

PREGNANCY: Pregnancy Category B. Reproduction studies have been performed in mice and rats at doses up to ten times the human dose and have revealed no evidence of impaired fertility or harm to the fetus due to cyclacillin. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

NURSING MOTHERS: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when cyclacillin is administered to a nursing woman.

Adverse Reactions

The oral administration of cyclacillin is generally well tolerated.

As with other penicillins, untoward reactions of the sensitivity phenomena are likely to occur, particularly in individuals who have previously demonstrated hypersensitivity to penicillins or in those with a history of allergy, asthma, fever, or urticaria.

The following adverse reactions have been reported with the use of cyclacillin: diarrhea (in approximately 1 out of 20 patients treated), nausea and vomiting (in approximately 1 in 50), and skin rash (in approximately 1 in 60). Isolated instances of headache, dizziness, abdominal pain, vaginitis, and urticaria have been reported. (See WARNINGS)

Other less frequent adverse reactions which may occur and that have been reported during therapy with other penicillins are: anemia, thrombocytopenia, thrombocytopenic purpura, leukopenia, neutropenia and eosinophilia. These reactions are usually reversible on discontinuation of therapy.

As with other semisynthetic penicillins, SGOT elevations have been reported.

Dosage and Administration

INFECTION*	ADULTS	CHILDREN
		Dosage should not exceed that in a dose higher than that for adults.
Respiratory Tract		
Tonsillitis & Pharyngitis**	250 mg q.i.d. in equally spaced doses	body weight <20 kg (<44 lbs.) 125 mg q.i.d. in equally spaced doses body weight >20 kg (>44 lbs.) 250 mg q.i.d. in equally spaced doses
Bronchitis and Pneumonia		
Mild or Moderate Infections	250 mg q.i.d. in equally spaced doses	50 mg/kg/day q.i.d. in equally spaced doses
Chronic Infections	500 mg q.i.d. in equally spaced doses	100 mg/kg/day q.i.d. in equally spaced doses
Otitis Media	250 mg to 500 mg q.i.d. in equally spaced doses depending on severity	50 to 100 mg/kg/day in equally spaced doses depending on severity
Skin & Skin Structures	250 mg to 500 mg q.i.d. in equally spaced doses depending on severity	50 to 100 mg/kg/day in equally spaced doses depending on severity
Urinary Tract	500 mg q.i.d. in equally spaced doses	100 mg/kg/day in equally spaced doses.

*As with antibiotic therapy generally, treatment should be continued for a minimum of 48 to 72 hours after the patient becomes asymptomatic or evidence of bacterial eradication has been obtained.

**In infections caused by Group A beta-hemolytic streptococci, a minimum of 10 days of treatment is recommended to guard against the risk of rheumatic fever or glomerulonephritis.

In the treatment of chronic urinary tract infection, frequent bacteriologic and clinical appraisal is necessary during therapy and may be required for several months afterwards.

Persistent infection may require treatment for several weeks.

Cyclacillin is not indicated in children under 2 months of age.

Patients with Renal Failure

Based on a dosage of 500 mg q.i.d., the following adjustment in dosage interval is recommended:

Patients with a creatinine clearance of >50 ml/min need no dosage interval adjustment.

Patients with a creatinine clearance of 30-50 ml/min should receive full doses every 12 hours.

Patients with a creatinine clearance of between 15-30 ml/min should receive full doses every 18 hours.

Patients with a creatinine clearance of between 10-15 ml/min should receive full doses every 24 hours.

In patients with a creatinine clearance of ≤10 ml/min or serum creatinine values of ≥10 mg%, serum cyclacillin levels are recommended to determine both subsequent dosage and frequency.

Wyeth Laboratories
Philadelphia, Pa. 19101

SPECIAL ARTICLES

Commencement Address

Lifelong Physician Competence: A Professional Responsibility

Edithe J. Levit, M.D.

President Brown, Dean Boren, Graduates of the Class of 1979, Members of the Faculty, Friends, and Guests: I am deeply honored by the invitation to deliver the Commencement Address to the graduating class of 1979. Although it is some 28 years since I was awarded the M.D. degree, I have a clear recollection of the emotional impact of this occasion.

And although there have been enormous changes in medical education since the time of my graduation, there is one concept that still remains: This moment marks a significant turning point in your professional development. No matter how much we may emphasize the intellectual challenge and the personal rewards of learning medicine, the M.D. degree tangibly documents the achivement of rigorous standards and demanding educational goals. You and your families can be justifiably proud of your accomplishments.

Today you have earned the right and the privilege to affix the title of "Doctor of Medicine" to your name. No other degree given by this or any other institution carries with it responsibilities comparable to those which you suddenly assume with commencement of your new lives as doctors. The manner in which you accept and fulfill these responsibilities will not only influence your own personal development as physicians but more importantly will play a vital role in the quality of your patients' lives in the years ahead.

You are entering the profession at a time when American medicine itself is entering a new era — an era of public accountability. The public is beginning to require "accountability" not only in terms of the cost and the availability of health care, but also in the quality of care it is receiving. These concerns are in large measure an outgrowth of the priorities and events of the past quarter century. Ironic though it may be, it is the advances of American medicine during this period that have generated many of the problems inherent in the health care system today. It hardly seems possible that I need look back only to the time of my own graduation to set the stage. It has been said that more information and understanding of the structure and function of the human body have accumulated since 1950 than in all previous years of recorded medical history.

In this brief span of time, the extraordinary advances in scientific knowledge and technology have provided incredibly new insights into the diagnosis and treatment of disease. We have witnessed the emergence of genetics, development of intracardiac surgery, introduction of antibiotics, and eradication of poliomyelitis, to name only a few.

While these advances have led to an increased level of sophistication in patient care, they have also resulted in a fragmented approach to the care of individual patients. As the complexity and volume of information have expanded, it has become impossible for faculty members and students to comprehend it all. Clinical medicine has become divided into specialty and subspecialty disciplines and this in turn has influenced the organization of medical schools, hospitals, and health care delivery systems. These same forces have had a profound effect upon the professional development of medical school graduates. Residency training and specialty practice, once the exception, have become the

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This address was presented before the University of South Florida College of Medicine 1979 graduating class, June 16, 1979, at Tampa.

Dr. Levit is Executive President, National Board of Medical Examiners, Philadelphia.

norm. With the establishment of the American Board of Family Practice ten years ago, essentially every aspect of patient care is now recognized through formal post-M.D. education and specialty board certification.

As we proceed into the last quarter of the 20th century, we find that the advances in knowledge, technology, and specialty care have created in their wake new problems for the public and profession alike. Containment of costs for medical services, improvements in the geographic and specialty distribution of physicians, and methods to assure quality health care are the principle challenges facing American medicine.

Even as these issues are being addressed, it is essential to recognize that there are many social, economic and cultural forces affecting the health of the American people — the high toll of poverty, environmental pollution, drug and alcohol abuse, increasingly sedentary but pressured lifestyles, disability and death on the highways, and a host of others. These factors are well beyond the responsibility and control of the medical community, and can only be addressed through the development of a consistent, public policy for health in this country.

It is this climate of concern that marks a new era of accountability in the provision of health care. While both the private and public sectors must participate in developing solutions to these complex health care issues, it is the medical profession itself to whom society has given its franchise for providing health care and assuring its quality. Obviously this is not a new concept — it has been the essence of medical practice for centuries. What is new is that physicians, collectively and individually, must rededicate themselves to the concept of accountability to their patients and to the public for the health care services they provide.

Many of these responsibilities are being discharged on behalf of the medical profession through the accountability of institutions and agencies responsible for the education, licensure, and certification of physicians. Thus far in your medical career, accountability to the public on your behalf has been provided by your medical school. This has been accomplished through selection criteria with emphasis placed upon your person qualifications as well as your academic capabilities, through a carefully designed curriculum with emphasis placed upon educating and training you to qualify for the practice of medicine and finally, today, through the faculty judgment that you have indeed met this institution's goals and standards and are therefore qualified to receive the M.D. degree.

As you are all too well aware, further public accountability for your competence to practice medicine will be provided through the use of extramural examinations, such as the National Boards or FLEX, which together with the M.D. degree and other prerequisites form the basis for physician licensure. Through this process the public is assured that individuals legally authorized to provide patient care are indeed competent to do so.

For those of you seeking to qualify as specialists, following completion of approved residency training, once again extramural examinations under the auspices of the individual specialty boards will provide the public with assurance that you have achieved a level of competence that qualifies you as a specialist in a given discipline.

Until recently, once the license to practice medicine was granted by a state medical board, the physician could be expected to maintain this privilege for life. Similarly, the certificate issued by a specialty board served as a lifetime credential. And until recent time, the maintenance of competence by the practicing physician has been a personal and voluntary responsibility with no extrinsic forces mandating either his continuing educational efforts or an assessment of competence beyond initial licensure and certification.

Now, the medical profession, through its agencies and societies, has clearly acknowledged the need and its responsibility for assuring the continuing competence of practicing physicians. This concept is being advocated and implemented through an ever-growing commitment to mandatory continuing education, relicensure, recertification, and critical monitoring of the individual physician's professional activities.

Extramural evaluation procedures at any level can and do provide reliable and valid assessments of the cognitive components of competence, namely, the knowledge, understanding, and clinical judgment essential for the recognition and management of the problems of patients. However, examinations cannot measure and assure other equally important aspects of physician competence such as the moral and ethical components of a physician's actions and behavior; the ability to interact effectively and appropriately with patients, families, and other health professionals; conscientiousness, and the willingness to assume responsibility, to name just a few.

The vital importance of these behavioral characteristics received special attention in the remarks made recently by the Chairman of the American Board of Internal Medicine, Dr. Richard Reitemeier: "The science of medicine must be always evident in the actions of the physician, but must never alone be the fulfillment of his responsibilities to his patient. Traditionally, physicians have divided medicine into its art and its science . . . There is no art and science of medicine, but rather, medicine is an example of the art and science of human compassion. And in that word 'compassion,' not its root 'passion' — a word that speaks to involvement, to vigor,

to action, the motivation to become involved visibly in addressing the needs of a patient."

There is the perception in some quarters that scientific machine is incompatible with affection for human condition. In my view, those having this perception fail to recognize that in the totality of patient care and its outcome, science without art can be as ineffective as is art without science.

As physicians, your commitment to integrating the art and science of medicine represents a singularly important personal responsibility to your patients. As noted earlier, there are external mandates in the form of education, examination, and credentialing, all of which will help assure the public that you have the knowledge and cognitive skills to practice modern scientific medicine. It is incumbent upon you not only to maintain and update your medical knowledge, but equally important, as a personal commitment, to continually develop and enhance your ability to communicate, to understand, and to interact effectively with your patients.

In terms of your role as a physician, there is much more at stake than being "well liked" or "popular" with your patients and your peers. Your ability to relate effectively with your patients will directly influence your effectiveness in providing care. To gain the patient's understanding and confidence is to achieve a cooperative effort between yourself and the patient directed toward meeting a common goal, namely, the patient's welfare.

The manner in which you as individual professionals accept and meet the challenge of maintaining your competence — in the broadest sense of the word — will determine the extent to which you can attain accountability for the public trust which society has placed upon the medical profession.

Today, as you leave medical school and enter the next phase of the educational continuum, it is my hope that you will accept the principle that continued learning, and the continuing assurance of your competence as a physician, is a lifelong commitment.

As stated simply and eloquently by Dr. John Millis:

> We can no longer speak of medicine as a learned profession. Rather, we must speak of it as a learning profession. A century ago we could accurately describe a profession such as medicine . . . as being learned. The volume of knowledge was such that it could be completely mastered in a reasonable course of study. Further, the rate of increase and change in that knowledge was so slow that initial mastery was valid throughout the lifetime of practice. In the last quarter of the 20th century, this is no longer true; the rate of increase in the volume of knowledge is explosive. If a man devoted his entire life to the study of his discipline or profession, he could not master it completely. Thus, we can no longer think of mastery as an achievable event but as a continuing process. The physician must be regarded as one engaged in a continuing process of *learning* his profession, not as one who has merely *learned* it at some time in the past.

It is through this commitment to both the science and the art of medicine that you can fulfill your personal and professional responsibilities — to your patients, to your colleagues, and to yourselves — and thereby your accountability for the quality of care that you provide in the practice of medicine.

In closing, I wish for each one of you that full measure of happiness, usefulness, and personal gratification that we, as members of the medical profession, are privileged to enjoy. And I leave you with one final thought: As this day marks a major turning point in your professional development, so too does this moment mark a significant transition in your life — you are no longer a medical student, you are now a student of medicine.

Charge to the Graduating Class of 1979

Commencement Ceremony, June 16, 1979

Anthony J. Reading, M.D.

You have given a great deal of yourselves. And you have your reward. But the challenge isn't over; much more will still be asked of you. This profession which you have now this morning joined has never been an easy one. But those who love and cherish it, and respect its ancient heritage and its values, forever keep on being rewarded.

During the last three years, we have taught you all the knowledge and skill necessary to begin the practice of medicine. We have taught you both the art and the science involved in caring for your patients and about

Dr. Reading is Professor and Chairman, Department Psychiatry, University of South Florida College of Medicine, Tam

them. We have not taught you anything, however, about taking care of yourselves. For, sadly, this is something that we ourselves know little about. It is becoming increasingly clear that physicians who fail to take care of themselves lose the ability to take care of others.

Take time, therefore, to take care of yourselves, of your own health and well-being, and to care about your families. Cherish and preserve the enthusiasm and excitement which you now invest in your work. Replenish your knowledge and your skills so that you do not become arrogant and self-satisfied. Do not grow blind to the needs of the communities in which you live, do not grow deaf to the cries of the patients whom you serve, and do not be afraid to speak out when necessary.

The power to heal is elusive. If you do not take proper care of yourselves, you will lose it. The lamp that we have passed along to you today must be kept polished, otherwise it will tarnish. You must continue to keep it filled with oil or the flame will go out.

We are most proud of you today. We have enjoyed you and you have enriched our lives by being here. We wish you great success. In the name of the Faculty of Medicine, I charge you to take care of yourselves so that you will always be able to give care to others.

Oath of the Class University of South Florida College of Medicine

I do freely and solemnly pledge this oath as a covenant with all human kind. My patients are fellow creatures whose dignity and privacy I shall ever respect. The responsibility which I assume today with gladness, courage, and humility will ever place foremost my patients' best welfare. I will treat my patients as I myself would wish to be treated. I will use my knowledge and art with all diligence and care to the best of my ability, consistent with the rich traditions of my profession. My knowledge I will neither defer to correct nor fail to enrich. The debt I owe to others for advances in science and for their instruction to me, I shall gladly repay by increasing the skill of my practice and by the creation and application of new knowledge. So shall I honor my teachers. All that I know and learn I shall freely share with others so that succeeding classes will have new footprints to follow. So long as I do these things may the enjoyment of the life and practice of my art be granted. But should I violate this covenant, then may I lose the rewards of my profession just as I will have lost my honor.

Hollis G. Boren, M.D.

This oath was written by Dr. Boren and he has read it at commencement for the past two years.

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ORGANIZATION

Multimillion Dollar Adjustment in Worker's Compensation Fee Schedule Accomplished

The Florida Medical Association has succeeded in obtaining a 35% increase in the Worker's Compensation Medical and Surgical Fee Schedule effective July 1, 1980. It represents an increase of approximately $16 million for the 4,150 doctors handling Worker's Compensation cases in the State. In addition to the across the board increase, the Division of Worker's Compensation has finally agreed to recognize three levels of initial and follow-up office and hospital visits, and five levels of consultations. Since the last report in JFMA (June 1976), the Division has also recognized the five-digit coding and nomenclature predominantly used nationwide and in Florida since 1971.

The FMA's 1979 House of Delegates charged that ". . . if no satisfactory adjustment is made in the Surgical and Medical Fee Schedule . . ." by the 1979 Legislature that a petition be initiated to request an increase in the fee schedule. The new Worker's Compensation Law did not address the fee schedule, so a petition was filed under the Florida Administrative Procedures Act on October 5, 1979. The petition requested recognition of three levels of office and hospital visits, instead of one, and a 35% across the board increase in the fee schedule.

On December 10, 1979, a public hearing was held in Tallahassee to present the Association's petition. Testimony was presented by James F. Richards Jr., M.D., Chairman of the Committee on Worker's Compensation; Richard S. Hodes, M.D., President; and John B. Richardson Jr., Association staff. No opposition to the petition was expressed at the hearing.

In early March, the Association was advised a rule had been promulgated by the Division of Worker's Compensation, pursuant to the petition of the Association, granting the increase in the Medical and Surgical Fee Schedule effective July 1, 1980. The three levels of office and hospital visits and five levels of consultation should help tremendously in obtaining internal medical providers for injured workmen in Florida.

The estimated additional $16 million in payments does not truly reflect the impact of the increase, because, according to the Division of Worker's Compensation, many insurance carriers were already paying amounts above the fee schedule. The $16 million takes into account that many carriers were already paying above the fee schedule level. This apparently was due to the realization that the fee schedule was woefully inadequate, although no information could be obtained to confirm this.

The Division of Worker's Compensation will provide a copy of the new fee schedule to each physician as soon as they are printed.

As long as we are uncertain about things there is some hope for us. People with an open mind will go on searching for answers.

Two-Part Physical Fitness Symposium Headlines Annual Meeting Scientific Program

A two-part symposium will underscore the theme of "Physical Fitness" for the 106th Annual Meeting of the Florida Medical Association.

According to Calvin W. Martin, M.D., of Arcadia, Annual Meeting General Program Chairman, finalization of the format for the Symposium on Physical Fitness marks completion of the scientific sessions scheduled for Wednesday, May 7, to Saturday, May 10, at the Diplomat Hotel in Hollywood.

The sessions on physical fitness are scheduled for Thursday afternoon and Friday morning, May 8-9, under the co-sponsorship of the FMA Committee on Physical Fitness and the Florida Academy of Family Physicians. James B. Perry, M.D., of Fort Lauderdale, Chairman of the FMA Committee on Physical Fitness, is Program Chairman for the Symposium.

FMA-recognized specialty groups will present 33 scientific sections during the meeting, Dr. Martin said. Four hours of Pfizer Laboratories' popular "Dialogue" programs, divided between Thursday afternoon and Friday morning; Programmed Instruction with the Wyeth Laboratories AutoTutors; and approximately 30 scientific and educational exhibits will round out the scientific program.

The Medical Education Committee of the Florida Medical Foundation, an organization accredited for continuing medical education, has approved the scientific program for up to 20 hours of American Medical Association Category I Credit, Dr. Martin announced. Application has been made to the American Academy of Family Physicians for designation of Prescribed Credit for certain elements of the program.

Florida's three medical schools — the University of Miami School of Medicine, Miami; the University of South Florida College of Medicine, Tampa; and the University of Florida College of Medicine, Gainesville — as well as the FMF Medical Education Committee are co-sponsoring the program with the FMA.

Here is the complete program:

WEDNESDAY AFTERNOON — MAY 7

SECTION ON INTERNAL MEDICINE

(Co-sponsored by American College of Physicians and Florida Society of Internal Medicine)

Wednesday — 1:00 p.m. to 4:15 p.m.
Michael J. Pickering, M.D., Tampa
Program Chairman

"Physician Fitness After Fifty"

"Historical Aspects for Exercise After Fifty," Michael J. Pickering, M.D., Associate Professor and Assistant Director, Division of Nephrology, University of South Florida College of Medicine, Tampa.

"Physiology of Aging," Roy H. Behnke, M.D., Professor and Chairman, Department of Internal Medicine, University of South Florida College of Medicine, Tampa.

"Physiological Changes Due to Conditioning Over Fifty," Albert Kattus, M.D., Director, Cardiac Rehabilitation, Centinela Hospital Medical Center, Inglewood, Calif., and Clinical Professor of Medicine, UCLA School of Medicine, Los Angeles, Calif.

"Physical Conditioning and Coronary Artery Disease," Stephen P. Glasser, M.D., Associate Professor and Director, Cardiovascular Medicine, University of South Florida College of Medicine, Tampa.

"Exercise Program for the Physician Over Fifty," George Sheehan, M.D., Redbank, N. J.

THURSDAY AFTERNOON — MAY 8

DIALOGUE

(Presented through the Courtesy of Pfizer Laboratories and Roerig Division of Pfizer Pharmaceuticals)
Thursday — 1:00 p.m. to 4:30 p.m.

"Parenteral Antibiotics," Thomas Hoffman, M.D., Associate Professor of Medicine, Division of Infectious Diseases, University of Miami School of Medicine, Miami.

"Management of Hypertension," Barry Materson, M.D., Associate Professor of Medicine, University of Miami School of Medicine, and Assistant Chief, Medical Service, Miami Veterans Administration Medical Center, Miami.

"The Clinical Significance of Coronary Artery Spasm" (Film and Monograph)

SYMPOSIUM ON PHYSICAL FITNESS (PART I)

(Co-sponsored by FMA Committee on Physical Fitness and Florida Academy of Family Physicians)
Thursday — 1:30 p.m. to 5:00 p.m.
James B. Perry, M.D., Ft. Lauderdale
Program Chairman

Opening Remarks — Richard S. Hodes, M.D., President, Florida Medical Association.

"American Life-Styles," T. Byron Thames, M.D., President-Elect, Florida Medical Association.

"Some Tried and True Rules of the Road for Joggers," George A. Sheehan, M.D., Medical Editor, Runner's World Magazine, Red bank, New Jersey.
"Who Should Receive Exercise Testing?" Stephen P. Glasser, M.D., Associate Professor of Medicine; Director, Division of Cardiovascular Medicine, University of South Florida College of Medicine, Tampa, Florida.
"The Aged Runner," Thomas Pagan, 81-year-old Marathoner.
Coffee Break
"Some Mental Aspects of Physical Fitness," Paul S. Jarrett, M.D., Miami.
"Governor's Council on Physical Fitness," James J. "Jimmy" Carnes, Executive Director of the Governor's Council on Physical Fitness and Head Coach for the 1980 U.S. Olympic Team in Track and Field.
Questions and Answers
Adjournment

SECTION ON CHEST MEDICINE

(Co-sponsored by Florida Chapter, American College of Chest Physicians, and Florida Thoracic Society)
Thursday — 1:30 p.m. to 5:30 p.m.
Wilbur G. Avery, M.D., South Miami
Program Chairman
"Current Concepts: Pulmonary Hypertension and Pulmonary Edema"

Moderators:
Wilbur G. Avery, M.D., Chief, Division of Pulmonary Diseases, South Miami Hospital, Miami.
Jose Landa, M.D., Associate, Division of Pulmonary Diseases, Mt. Sinai Hospital, Miami Beach.
Allan L. Goldman, M.D., Associate Professor of Internal Medicine and Chief, Pulmonary Disease Section, University of South Florida College of Medicine and Tampa Veterans Administration Hospital, Tampa.
Introduction — Wilbur G. Avery, M.D., Program Chairman, South Miami.
"The Pathogenesis of Pulmonary Edema," Kenneth Brigham, M.D., Professor of Medicine and Director of Pulmonary Circulation Center, Vanderbilt University School of Medicine, Nashville, Tenn.
"Clinical Aspects, Pulmonary Hypertension and Pulmonary Edema," Roy H. Behnke, M.D., Professor and Chairman, Department of Internal Medicine, University of South Florida College of Medicine, Tampa.
"Radiologic Aspects, Pulmonary Hypertension and Pulmonary Edema," Luis Martinez, M.D., Associate Director of the Radiology Department, Mt. Sinai Medical Center, Miami Beach, and Professor of Radiology, University of Miami School of Medicine, Miami.
"Colloid Osmotic Pressure in the Critical Care Unit," Charles Sprung, M.D., Chief, Medical Intensive Care Unit, and Chief, Respiratory Therapy Unit, Veterans Administration Hospital, Miami.

SECTION ON RHEUMATOLOGY

(Co-sponsored by Florida Society of Rheumatology and Florida Chapter, Arthritis Foundation)
Thursday — 1:30 p.m. to 4:30 p.m.
Charles B. Kahn, M.D., Hollywood
Program Chairman

"Non-articular Rheumatism," John Calabro, M.D., Director, Division of Rheumatology, St. Vincent Hospital, and Professor of Medicine and Pediatrics, University of Massachusetts Medical School, Worchester, Mass.
"Current Therapy of Rheumatoid Arthritis," John Calabro, M.D., Worchester, Mass.
"Complement Deficiency and Rheumatic Disease," Luis Espinoza, M.D., Associate Professor of Medicine, University of South Florida College of Medicine, Tampa.

FRIDAY MORNING — MAY 9

SECTION ON EMERGENCY MEDICINE

(Co-sponsored by Florida Chapter, American College of Emergency Physicians)
Friday — 8:00 a.m. to 10:45 a.m.
Alan M. Altman, Miami
Program Chairman

"Evaluation of the Comatose Child," Robert Cullen, M.D., Chief Pediatric Neurologist, Variety Children's Hospital, Miami.
"Pediatric Cardiac Emergencies," Arthur Pickoff, M.D., Fellow in Pediatric Cardiology, Jackson Memorial Hospital, Miami.
"The Emergency Diagnosis of Meningitis," Alan M. Altman, M.D., Chairman, FMA Section on Emergency Medicine, Miami.

SECTION ON ORTHOPEDIC SURGERY (SECTION I)

(Co-sponsored by Florida Orthopedic Society)
Friday — 8:00 a.m. to 10:45 a.m.
Richard M. Fry, M.D., Gainesville
Program Chairman

Welcome — Charles A. Mead, M.D., President, Florida Orthopedic Society, Jacksonville.
"Midcarpal Instability — How Often Have I Missed the Diagnosis?" Francis M. Howard, M.D., Bradenton.
"Arthroscopic Surgery — A Review of 200 Cases in Private Practice," Terrence J. Barry, M.D., Hialeah.
"Anterior Cruciate Insufficiency of the Knee," Peter A. Indelicato, M.D., Assistant Professor of Orthopedic Surgery, University of Florida College of Medicine, Gainesville.
"Blind Nailing of the Femur — A Series of About 48 Cases," Harry L. Tucker, M.D., Orlando.
"Experiences with Ender Nails," Joseph A. Visconti, M.D., Leesburg.
Adjournment

SYMPOSIUM ON PHYSICAL FITNESS (PART II)

(Co-sponsored by FMA Committee on Physical Fitness and Florida Academy of Family Physicians)
Friday — 8:30 a.m. to 10:45 a.m.
James B. Perry, M.D., Ft. Lauderdale
Program Chairman

Coffee
"Heat and Physical Activity," Arthur J. Pearl, M.D., Clinical Assistant Professor, Department of Orthopaedic Surgery and Rehabilitation, University of Miami College of Medicine, Miami.
"Physical Fitness, Obesity, and Diabetes Mellitus," Samuel E. Crockett, M.D., Coordinator, Medical Education, Orlando Regional Medical Center, Orlando.

"The Physically Fit Child," Christian W. Zaunder, Ph.D., College of Physical Education, Health and Recreation at the University of Florida, Gainesville.
"Today's Teenage Girl," Ann Rousseau, Director, Girls Physical Education Program, Pine Crest High School, Fort Lauderdale.
Question and Answer Panel
Adjournment

DIALOGUE

(Presented through the Courtesy of Pfizer Laboratories and Roerig Divisions of Pfizer Pharmaceuticals)
Friday — 8:30 a.m. to 10:45 a.m.

"Current Diabetes Therapy," Jay Skyler, M.D., Associate Professor of Medicine and Pediatrics, and Director, South-eastern Florida Regional Diabetes Program, University of Miami School of Medicine, Miami.
"Exercise-Induced Bronchospasm," David Tinkelman, M.D., Associate Professor of Clinical Medicine, Georgia State University School of Health Sciences, and Atlanta Allergy Clinic, Atlanta, Ga.

FRIDAY AFTERNOON — MAY 9

SECTION ON ORTHOPEDIC SURGERY (SECTION II)

(Co-sponsored by Florida Orthopedic Society)
Friday — 2:00 p.m. to 5:00 p.m.
Richard M. Fry, M.D., Gainesville
Program Chairman

"Emergencies in Orthopedics," Raymond E. Bellamy, M.D., Tallahassee.
"Management of Pelvic Fractures," Dana C. Mears, M.B., B.Ch., Ph.D., Associate Professor of Orthopedic Surgery and Director of Orthopedic Research, University of Pittsburgh School of Medicine, Pittsburgh, Pa.
Demonstration of Fixation of Pelvic Fractures — Dana C. Mears, M.B., B.Ch., Ph.D., Pittsburgh, Pa.

SECTION ON PREVENTIVE MEDICINE

(Co-sponsored by Florida Society for Preventive Medicine)
Friday — 2:00 p.m. to 6:00 p.m.
James T. Howell, M.D., Tallahassee
Program Chairman

"Review of Diabetes Mellitus, Etiology, Diagnosis and Modern Management," Jay S. Skyler, M.D., Associate Professor of Medicine and Pediatrics, Diabetes and Endocrinology Unit, University of Miami School of Medicine, Miami.
"Epidemiological Update — State of Florida," Robert A. Gunn, M.D., State Epidemiologist, Tallahassee.
"Florida's Public Health," James T. Howell, M.D., State Health Officer and Staff Director, Health Program Office, Tallahassee.

SECTION ON RADIOLOGY (SECTION I)

(Co-sponsored by Florida Radiological Society)
Friday — 2:00 p.m. to 6:00 p.m.
Anthony S. Calabrese, M.D., Orlando
Program Chairman

Welcome — Sylvan H. Sarasohn, M.D., President, Florida Radiological Society, North Miami.
"Pediatric Renal Neoplasia," David S. Hartman, Lt. Cmdr., MC, USNR, Chief, Division of Genitourinary Radiologic Pathology, Armed Forces Institute of Pathology.
"Radiologic-Pathologic Correlation of Common Patterns of the Upper Gastrointestinal Tract: Part I," Joel F. Lichtenstein, Lt. Col., MC, USAF, Chief, Division of Diagnostic Radiologic Pathology, Armed Forces Institute of Pathology.
"Radiologic-Pathologic Correlation of Common Patterns of the Upper Gastrointestinal Tract: Part II," Joel F. Lichtenstein, Lt. Col., MC, USAF.
"Newer Concepts of Carotid Ultrasound," J. J. Crittenden, M.D., West Florida Medical Center, Pensacola.
"Renal Cystic Disease," David S. Hartman, Lt. Cmdr., MC, USNR.

SECTION ON NEPHROLOGY

(Co-sponsored by Florida Society of Nephrology)
Friday — 2:00 p.m. to 6:00 p.m.
John E. Cunio, M.D., Miami
Program Chairman

"Review of Basic Immunology," Jay Sanders, M.D., Professor of Medicine, University of Miami School of Medicine, and Director of Medical Affairs, Mt. Sinai Hospital, Miami Beach.
"Immunopathogenesis of Glomerular Disease," Guido Perez, M.D., Associate Professor of Medicine, University of Miami School of Medicine, and Director Dialysis Service, VA Hosital, Miami.
"Contribution of Renal Biopsy to Diagnosis of Glomerular Disease," Victoriano Pardo, M.D., Professor of Pathology, University of Miami School of Medicine, and Director, Electronmicroscopy Laboratory, VA Hospital, Miami.
"Plasma Exchange Therapy in Renal Disease," Dana Shires, M.D., Professor of Medicine and Chief, Nephrology Service, University of South Florida College of Medicine, Tampa.

SECTION ON PATHOLOGY

(Co-sponsored by Florida Society of Pathologists)
Friday — 2:00 p.m. to 6:00 p.m.
Gabino S. Cuevas, M.D., Boynton Beach
Program Chairman

"Cyto and Plasmaphoresis in a Community Hospital," Lynn Leverette, M.D., Associate Pathologist, South Miami Hospital, and Clinical Assistant Professor, University of Miami School of Medicine, Miami.
"Update on Ocular Pathology for the General Pathologist," C. Ian Hood, M.D., Professor of Pathology, University of Florida College of Medicine, and Chief of Laboratory Services, Veterans Administration Medical Center, Gainesville.
"Sudden Cardiac Death in Athletes," Joe Davis, M.D., Chief Medical Examiner, Dade County, and Professor of Pathology, University of Miami School of Medicine, Miami; and Azorides Morales, Professor and Chairman, Department of Pathology, University of Miami School of Medicine, Miami.
Alfred Lewis Award Lecture — (Speaker and Topic to be Announced).

SECTION ON GASTROENTEROLOGY

(Co-sponsored by Florida Gastroenterologic Society and Florida Society for Gastrointestinal Endoscopy)
Friday — 2:00 p.m. to 6:00 p.m.
Arvey I. Rogers, M.D., Miami
Program Chairman

"Esophagus and Stomach"

"Selecting Diagnostic Procedures for Esophageal Disease," Arvey I. Rogers, M.D., Professor of Medicine, University of Miami School of Medicine, and Chief, Gastroenterology Section, VA Hospital, Miami.

"Heartburn: Rational Approaches to Management," H. Worth Boyce, M.D., Professor of Medicine and Director, Gastroenterology Division, University of South Florida College of Medicine, Tampa.

"The Esophageal Prosthesis: A Management Option in Esophageal Cancer," H. Worth Boyce, M.D., Tampa.

"Disorders of Gastric Emptying," Arvey I. Rogers, M.D., Miami.

Pancreas and Pot Pourri

"Endoscopic Retrograde Cholangiopancreatography," Jeffrey Raskin, M.D., Associate Professor of Medicine, University of Miami School of Medicine, and Director, Endoscopy Unit, Jackson Memorial Hospital, Miami.

"Pancreatic Pseudocysts: Management Options," Jamie S. Barkin, M.D., Assistant Professor of Medicine, University of Miami School of Medicine, Miami.

"Ampullary Stenosis: Something to Think About in Abdominal Pain Evaluation," Jeffrey Raskin, M.D., Miami.

"Non-Operative Abdominal Exploration: Laparoscopy," H. Worth Boyce, M.D., Tampa.

"Colon: Growths and Irritations"

"Tracking Down the Hemoccult + Stool," Juergen Nord, M.D., Associate Professor of Medicine, University of South Florida College of Medicine, and Director, GI Division, Tampa General Hospital, Tampa.

"Should I Be Excited About the Small, Benign Polyp?" John P. Christie, M.D., General Surgeon and GI Endoscopist, Consultant Staff, VA Hospital, Miami.

"Screening the High-Risk Patient for Colon Ca," Juergen Nord, M.D., Tampa.

"Pseudomembranous Enterocolitis: Status Report," Jamie S. Barkin, M.D., Miami.

SECTION ON THORACIC AND CARDIOVASCULAR SURGERY

(Co-sponsored by Florida Society of Thoracic and Cardiovascular Surgeons)
Friday — 2:00 p.m. to 4:00 p.m.
G. H. Welch Jr., M.D., St. Petersburg
Program Chairman

"Different Manifestations of Sepsis in Thoracic Surgical Patients, Including Diagnosis and Treatment," Frank C. Spencer, M.D., Professor and Chairman, Department of Surgery, New York University Medical Center, New York, N.Y.

"Should the Diagnosis and Postoperative Therapy for Bronchogenic Carcinoma be Managed by the Thoracic Surgeon or the Pulmonary Internist?" (Panel)
Moderator: Frank C. Spencer, M.D., New York, N.Y.
Participants:
James A. Alexander, M.D., Chief and Associate Professor, Division of Thoracic and Cardiovascular Surgery, University of Florida College of Medicine, Gainesville.
Richard J. Thurer, M.D., Associate Professor of Surgery, University of Miami School of Medicine, Miami.
Donald O. Weber, M.D., Assistant Professor, Department of Surgery, University of South Florida College of Medicine, Tampa.

SECTION ON PEDIATRICS AND NUCLEAR MEDICINE

(Co-sponsored by Florida Pediatric Society and Florida Association of Nuclear Physicians)
Friday — 2:00 p.m. to 6:00 p.m.
Robert H. Threlkel, M.D., Jacksonville
George N. Sfakianakis, M.D., Miami
Program Co-Chairmen

"Ultrasonography in Pediatrics"

Introduction — Aldo Serafini, M.D., Associate Professor, Division of Nuclear Medicine, Department of Radiology, University of Miami School of Medicine, Miami.

"Echocardiography," Pedro L. Ferrer, M.D., Associate Professor of Pediatrics, Division of Pediatric Cardiology, University of Miami School of Medicine, Miami.

"Abdominal Ultrasonography," Jane Frank, M.D., Assistant Professor of Radiology, University of Miami School of Medicine, Miami.

"Nuclear Medicine in Pediatrics," George N. Sfakianakis, M.D., Associate Professor of Radiology, Division of Nuclear Medicine, University of Miami School of Medicine, Miami.

"New Developments in Acute Leukemia in Childhood," Sarah Strandjord, M.D., Division of Hematology and Oncology, Department of Pediatrics, University of Florida College of Medicine, Gainesville.

"New Developments in Pediatric Infectious Diseases," Jack Hutto, M.D., Division of Infectious Diseases and Immunology, All Children's Hospital, St. Petersburg, and Assistant Clinical Professor of Pediatrics, University of South Florida College of Medicine, Tampa.

SECTION ON COLON AND RECTAL SURGERY

(Co-sponsored by Florida Society of Colon and Rectal Surgeons)
Friday — 2:00 p.m. to 6:00 p.m.
Shed Roberson, M.D., Daytona Beach
Program Chairman

"Changing Concepts in the Management of Colorectal Cancer," Malcolm Veidenheimer, M.D., President-Elect, American Society of Colon and Rectal Surgeons, and Head, Department of Colon and Rectal Surgery, Lahey Clinic, Boston, Mass.

"Colonoscopy in Perspective 1980 — State of the Art," John Christie, M.D., South Miami.

"Management of Colonic Hemorrhage," Kimber Ward, M.D., Clearwater.

"Colon Cancer, Choice of Operation," Emmet Ferguson, M.D., Jacksonville.

"How I Do It, Management of Pilonidal Disease, Fissure, Fistula, Hemorrhoids" (Panel)
Moderator: William P. Scherer, M.D., Ft. Lauderdale.
Participants:
Matt Larkin, M.D., Miami.
Malcolm Veidenheimer, M.D., Boston, Mass.
John Cheleden, M.D., Daytona Beach

SECTION ON OTOLARYNGOLOGY

(Co-sponsored by Florida Society of Otolaryngology)
Friday — 2:00 p.m. to 6:00 p.m.
Hueston C. King, M.D., Coral Gables
Program Chairman

Welcome — Hueston C. King, M.D., President and Program Chairman, Florida Society of Otolaryngology, Coral Gables.

"Science and Politics in Otolaryngology," Harry McCurdy, M.D., Executive Director, American Council of Otolaryngology.

"Peritonsillar Abscess Revisited," John Isaacs, M.D., Senior Resident, University of Florida College of Medicine, Gainesville.

"Laser Surgery," Brian Mitchell, M.D., Resident, University of Miami School of Medicine, Miami.

"Neuroesthesioblastoma," Pedro Montano-Martinez, M.D., Senior Resident, University of South Florida College of Medicine, Tampa.

SECTION ON ENDOCRINOLOGY

(Co-sponsored by Florida Endocrine Society)
Friday — 2:00 p.m. to 6:00 p.m.
Elliot G. Levy, M.D., North Miami Beach
Louis B. Chaykin, M.D., North Miami Beach
Program Co-Chairmen

Welcome — Lawrence M. Fishman, M.D., President, Florida Endocrine Society, Miami.

"Current Thoughts on the Use of Radioiodine in Treatment of Hyperthyroidism," Colum A. Gorman, M.B., B.Ch., The Mayo Clinic, Rochester, Minn.

"Screening for Neonatal Hypothyroidism," William W. Cleveland, M.D., Professor and Chairman, Department of Pediatrics, University of Miami School of Medicine, Miami.

"Clinical Aspects of Spontaneously Relapsing Hyperthyroidism," Elliot G. Levy, M.D., North Miami Beach.

"Therapeutic Modalities in Thyroid Cancer," Colum A. Gorman, M.B., B.Ch., Rochester, Minn.

SECTION ON PSYCHIATRY (SECTION I)

(Co-sponsored by Florida Council of District Branches of the American Psychiatric Association)
Friday — 2:00 p.m. to 6:00 p.m.
Fred A. Peisner, M.D., Orlando
Program Chairman

"Medical Update: Behavioral Problems of Children and Adolescents"

Introduction — Fred A. Peisner, M.D., Program Chairman and Moderator, Orlando.

"Differential Diagnosis of Hyperactive Behavior," Marty Lazoritz, M.D., Clinical Assistant Professor of Psychiatry, University of Florida College of Medicine, Orlando.

"Early Signs of Organic Problems and Learning Disorder," Archie Silver, M.D., Professor of Psychiatry and Chief of the Division of Child and Adolescent Psychiatry, University of South Florida College of Medicine, Tampa.

"Neurological Evaluation of Psychiatric Disorders," Stephen Rosenberg, M.D., Orlando.

"Current Behavioral Problems of Youth I" (Panel)

SECTION ON NEONATAL-PERINATOLOGY

(Co-sponsored by Florida Society of Neonatal-Perinatologists)
Friday — 2:00 p.m. to 6:00 p.m.
Gregor Alexander, M.D., Orlando
Program Chairman

"Asphyxia Neonatorum," Eduardo Bancalari, M.D., Associate Professor of Pediatrics and Director of Newborn Medicine, University of Miami School of Medicine, Miami.

"Persistent Fetal Circulation," William Fox, M.D., Director of Neonatal Intensive Care Unit, Children's Hospital of Philadelphia, and Associate Professor of Pediatrics, University of Pennsylvania, Philadelphia, Pa.

"Respiratory Intervention in the Newborn," Gregor Alexander, M.D., President, Florida Society of Neonatal-Perinatologists, and Director, Neonatal Intensive Care Unit, Orlando Regional Medical Center, Orlando.

"Apnea of Prematurity," Tilo Gerhardt, M.D., Assistant Professor of Pediatrics, Division of Newborn Medicine, University of Miami School of Medicine, Miami.

"Patent Ductus Arteriosus," Jeane McCarthy, M.D., Neonatologist, All Children's Hospital, St. Petersburg.

"Transcutaneous Oxygen Monitor," Marsha Wagaman, M.D., Neonatologist, All Children's Hospital, St. Petersburg.

SATURDAY MORNING — MAY 10

SECTION ON NEUROSURGERY

(Co-sponsored by Florida Neurosurgical Society)
Saturday — 8:30 a.m. to 11:00 a.m.
Donald Giulianti, M.D., Hollywood
Program Chairman

Welcome — William E. Hoffmeister, M.D., President, Florida Neurosurgical Society, Winter Park.

"Legislative Activities of Concern for All FMA Members" (Speaker To Be Announced).

"Who Should Represent Physicians in Collective Bargaining: The AMA or a Physician's Union?"

Introduction — Donald Guilianti, M.D., Program Chairman, Hollywood.

"The Union's View," Stanley S. Peterson, M.D., President, American Federation of Physicians and Dentists.

"The AMA's View," Stephen J. Dresnick, M.D., Chairman, AMA Resident Physicians Section.

Round Table Discussion by Program Participants and Members of the Audience.

SECTION ON OBSTETRICS AND GYNECOLOGY

(Co-sponsored by Florida Obstetric and Gynecologic Society)
Saturday — 8:00 a.m. to 11:30 a.m.
Eric F. Geiger, M.D., Pensacola
Program Chairman

"Regionalization of Obstetrics in Florida — What Effects (so far) on Mother, Baby and Doctor?

Welcome and Introductory Remarks — Allan McLeod, M.D., Professor and Vice Chairman, Department of Obstetrics and Gynecology, University of Miami School of Medicine, Miami.

Recent Changes in the Care of Women During High Risk Pregnancy and Delivery," Amelia C. Cruz, M.D., Associate Professor and Director, Division of Maternal/Fetal Medicine, University of Florida College of Medicine, Gainesville.

"**Newborns — Are They Different Now?**" John Curran, M.D., Associate Professor of Pediatrics/Neonatology, University of South Florida College of Medicine, Tampa.

"**Private Obstetrical Practice — What's Happening?**" Eric F. Geiger, M.D., President, Florida Obstetric and Gynecologic Society, Pensacola.

"**Standards of Care in Obstetrics — What Are They Now?**" Edward J. Quilligan, M.D., Professor of Obstetrics and Gynecology, and Chief of Maternal-Fetal Medicine, University of California at Irvine.

"**Whither Obstetrics**" (A panel discussion with audience participation)

Participants:

Edward J. Quilligan, M.D., Irvine, Calif.

John Curran, M.D., Tampa

Eric F. Geiger, M.D., Pensacola

Mary Jo Sullivan, Director of Maternal-Fetal Medicine, University of Miami School of Medicine at Jackson Memorial Hospital, Miami

Robert A. Knuppel, M.D., M.P.H., Director of Maternal-Fetal Medicine, University of South Florida College of Medicine and Tampa General Hospital, Tampa

"**Contraception,**" Edward J. Quilligan, M.D., Irvine, Calif.

SECTION ON PSYCHIATRY (SECTION II)

(Co-sponsored by Florida Council of District Branches of the American Psychiatric Association)

Saturday — 8:00 a.m. to 12:00 noon

Fred A. Peisner, M.D., Orlando

Program Chairman

Introduction — Fred A. Peisner, M.D., Program Chairman and Moderator, Orlando.

"**Adolescent Suicide,**" Jose L. Llinas, M.D., Professor of Psychiatry and Chief of Student Mental Health, University of Florida College of Medicine, Gainesville.

"**Differential Diagnosis of the Quiet Child,**" Francine Gelfand, M.D., Clinical Assistant Professor of Psychiatry, University of Florida College of Medicine, Leesburg.

"**Children and Divorce,**" Thomas Dow, M.D., Clinical Assistant Professor of Family Medicine, University of South Florida College of Medicine, Orlando.

"**Behavioral Problems of Youth II**" (Panel)

SECTION ON OCCUPATIONAL HEALTH

(Co-sponsored by Florida Occupational Medical Association)

Saturday — 8:00 a.m. to 11:30 a.m.

Joseph A. Baird, M.D., Belleair Beach

Program Chairman

"Occult Trauma"

Welcome — Frederick C. Andrews, M.D., President, Florida Occupational Medical Association, Mount Dora.

"**Health Promotion in a Major Industry,**" John S. Jacoby, M.D., Medical Director, Honeywell, Inc., Minneapolis, Minn.

"**Occupational Health Hazards Among Farm Workers,**" Jack Griffiths, Ph.D., Department of Epidemiology, University of Miami School of Medicine, Miami.

"**Retrospective Study on Lung Cancer,**" William J. Blot, Ph.D., National Cancer Institute, Bethesda, Md.

"**Centuries-Old Cancer — Is It Possible?**" Francis L. Bergquist, M.D., Lakeland.

SECTION ON PEDIATRIC CARDIOLOGY

(Co-sponsored by Florida Association of Pediatric Cardiologists)

Saturday — 8:00 a.m. to 10:30 a.m.

Ben Victorica, M.D., Gainesville

Program Chairman

"Cardiac Surgery in Infants"

"**Open Heart Surgery: Techniques, Complications and Long-Term Effects,**" Gerard A. Kaiser, M.D., Department of Thoracic and Cardiovascular Surgery, University of Miami School of Medicine, Miami.

"**Intra and Postoperative Monitoring and Management,**" James A. Alexander, M.D., Department of Thoracic and Cardiovascular Surgery, University of Florida College of Medicine, Gainesville.

"**Ventricular Septal Defect: Pulmonary Banding vs. Early Closure — Surgical Results,**" Gerard A. Kaiser, M.D., Miami.

"**Atrioventricular Canal: Surgical Approach and Results,**" James A. Alexander, M.D., Gainesville.

SECTION ON PLASTIC AND RECONSTRUCTIVE SURGERY

(Co-sponsored by Florida Society of Plastic and Reconstructive Surgery)

Saturday — 8:00 a.m. to 10:00 a.m.

S. Anthony Wolfe, M.D., Miami

Program Chairman

"**Coverage of an Unstable Radionecrotic Trochanteric Ulcer,**" Daniel Gruber, M.D., University of Miami School of Medicine, Miami.

"**Application of Microsurgery,**" Felix Freshwater, M.D., University of Miami School of Medicine, Miami.

"**Concealed Approaches for the Repair of Facial Injuries,**" Mutaz B. Habal, M.D., University of South Florida College of Medicine, Tampa.

"**Research on Breast Implant Capsules in Dogs,**" Hollis Caffee, M.D., University of Florida College of Medicine, Gainesville.

SECTION ON ORTHOPEDIC SURGERY (SECTION III)

(Co-sponsored by Florida Orthopedic Society)

Saturday — 8:00 a.m. to 12:00 noon

Richard M. Fry, M.D., Gainesville

Program Chairman

Report from the American Academy of Orthopaedic Surgeons Board of Councilors

"**External Fixation in Acute Tibial Fractures,**" Robert Kleinhans, M.D., Jacksonville.

"**External Fixation in Infected Pseudoarthrosis,**" John Lozano, M.D., Jacksonville.

"**The Use of External Fixation,**" Joseph A. Visconti, M.D., Leesburg.

"**Staged Treatment of Complicated Fractures,**" Dana C. Mears, M.B., B.Ch., Ph.D., Associate Professor of Orthopedic Surgery and Director of Orthopedic Research, University of Pittsburgh School of Medicine, Pittsburgh, Pa.

Round Table Discussion

Dana C. Mears, M.B., B.Ch., Ph.D., Pittsburgh, Pa.

Robert Kleinhans, M.D., Jacksonville

John Lozano, M.D., Jacksonville

Joseph A. Visconti, M.D., Leesburg

SECTION ON RADIOLOGY (SECTION II)

(Co-sponsored by Florida Radiological Society)
Saturday — 8:00 a.m. to 11:00 a.m.
Anthony S. Calabrese, M.D., Orlando
Program Chairman

"Pelvic Mass Diagnosis by Ultrasound," J. J. Crittenden, M.D., West Florida Medical Center, Pensacola.

"Radiological-Pathological Correlation of Renal Neoplasia: Part I," David S. Hartman, Lt. Cmdr., MC, USNR, Chief, Division of Genitourinary Radiologic Pathology, Armed Forces Institute of Pathology.

"Radiological-Pathological Correlation of Renal Neoplasia: Part II," David S. Hartman, Lt. Cmdr., MC, USNR.

"Gastrointestinal Polyposis Syndrome," Joel E. Lichtenstein, Lt. Col., MC, USAF, Chief, Division of Diagnostic Radiologic Pathology, Armed Forces Institute of Pathology.

SECTION ON OPHTHALMOLOGY

(Co-sponsored by Florida Society of Ophthalmology)
Saturday — 8:00 a.m. to 10:00 a.m.
Thomas R. Bates, M.D., Orlando
Program Chairman
"Current Aspects of Vitrectomy"

"Vitrectomy in Endophthalmitis," Henry Gelender, M.D., Assistant Professor of Ophthalmology, Bascom Palmer Eye Institute and University of Miami School of Medicine, Miami.

"Anterior Vitrectomy Especially as Associated with Dislocated Lenses," Harry Flynn, M.D., Assistant Professor of Ophthalmology, Bascom Palmer Eye Institute and University of Miami School of Medicine, Miami.

"Vitrectomy in Trauma," Gary Abrams, M.D., Assistant Professor of Ophthalmology, Bascom Palmer Eye Institute and University of Miami School of Medicine, Miami.

"Diabetic Retinopathy Update," George Blankenship, M.D., Associate Professor of Ophthalmology, Bascom Palmer Eye Institute and University of Miami School of Medicine, Miami.

SECTION ON DERMATOLOGY

(Co-sponsored by Florida Society of Dermatology)
Saturday — 8:15 a.m. to 12:15 p.m.
William H. Eaglstein, M.D., Miami
Program Chairman

Welcome — Henry Menn, M.D., President, Florida Society of Dermatology, Miami.

"Cancer and Psoriasis Patients and PUVA," Kenneth M. Halprin, M.D., Professor of Dermatology, University of Miami School of Medicine, Miami.

"Retinoids and Cancer," Marilynne McKay, M.D., Dermatology Resident and Research Fellow, University of Miami School of Medicine, Miami.

"Experiences Treating Herpes," Kenneth Mehr, M.D.

"Lithium and the Psoriasis Patient," John J. DiGiovanna, M.D., Dermatology Resident, University of Miami School of Medicine, Miami.

"Radiotherapy and Skin Cancer," Robert S. Tomsick, M.D., Fellow in Chemosurgery, University of Miami School of Medicine, Miami.

"Infestations of Childhood," Lawrence Schachner, M.D., Assistant Professor of Dermatology, University of Miami School of Medicine, Miami.

"Recurrent Clear Cell Hidradenoma," Neal S. Penneys, M.D., Associate Professor, and Alexander Kowalczyk, M.D., Dermatology Resident, University of Miami School of Medicine, Miami.

SECTION ON MANAGEMENT OF PRIMARY BREAST CANCER

(Co-sponsored by Florida Society of Clinical Oncologists)
Saturday — 8:30 a.m. to 10:30 a.m.
Charles L. Vogel, M.D., Miami
Program Chairman

"Is Radical Surgery Really Necessary?" Everett V. Sugarbaker, M.D., Associate Professor of Surgery and Oncology, University of Miami School of Medicine, Miami.

"The Role of Definitive Radiation Therapy," Jay R. Harris, M.D., Assistant Professor of Radiation Therapy, New England Deaconess Hospital Joint Center for Radiation Therapy, Harvard Medical School, Boston, Mass.

"Systemic Adjuvant Therapy Update," Charles L. Vogel, M.D., Chief, Division of Breast Cancer, Comprehensive Cancer Center for the State of Florida, and Associate Professor of Oncology, University of Miami School of Medicine, Miami.

"Breast Reconstruction," Walter R. Mullin, M.D., Clinical Assistant Professor of Plastic Surgery, University of Miami School of Medicine, Miami.

SECTION ON ALLERGY AND IMMUNOLOGY

(Co-sponsored by Florida Allergy Society)
Saturday — 8:30 a.m. to 12:00 noon
Ira Finegold, M.D., Hollywood
Program Chairman

Welcome — Ira Finegold, M.D., Vice President, Florida Allergy Society, Hollywood.

"Relationships of Asthma and Gastroesophageal Reflux," Mark R. Stein, M.D., Clinical Assistant Professor of Medicine, University of South Florida College of Medicine, Tampa.

"Complement Advances and Clinical Application," Duane R. Schultz, Ph.D., Associate Professor of Medicine, University of Miami School of Medicine, Miami.

"Current Insect Sting Immunotherapy," Richard F. Lockey, M.D., Associate Professor of Internal Medicine, University of South Florida College of Medicine, Tampa.

SECTION ON NEUROLOGY

(Co-sponsored by Florida Society of Neurology)
Saturday — 9:00 a.m. to 12:00 noon
Manuel Mier, M.D., Venice
Program Chairman

"Recent Advances in Understanding and Managing Cerebral Vascular Diseases," Peritz Scheinberg, M.D., Professor and Chairman, Department of Neurology, University of Miami School of Medicine, Miami.

"Computed Tomography and Metrizamide Myelography of the Vertebral Column," Jerome J. Sheldon, M.D., Chief of Neuroradiology, Mt. Sinai Medical Center, Miami Beach.

"Update in the Use of Neuro-Stimulation in Neurological Diseases," Ross Davis, M.D., Chairman, Department of Neurosurgery, Mt. Sinai Medical Center, Miami Beach.

SECTION ON SURGERY
(Co-sponsored by Florida Chapter, American College of Surgeons)
Saturday — 9:30 a.m. to 11:00 a.m.
H. Quillian Jones Jr., M.D., Fort Myers
Program Chairman

"**Trauma,**" Jerry Mark Shuck, M.D., Professor and Chairman, Department of Surgery, Case Western Reserve University School of Medicine, Cleveland, Ohio.

SECTION ON PHYSICAL MEDICINE AND REHABILITATION
(Co-sponsored by Florida Society of Physical Medicine and Rehabilitation)
Saturday — 10:00 a.m. to 12:00 noon
Hector A. Freytes, M.D., Miami
Program Chairman

"**The New Development in Electrotherapy of Pain, Spasms and Spasticity,**" W. T. Liberson, M.D., Ph.D., Brooklyn, N.Y.
Adjournment

Women M.D.'s Dinner Scheduled

In order to promote more active involvement of women M.D.'s in medical association activities at all levels, Dr. Charlotte H. Kerr, Past President of the American Women's Medical Association will host a dinner during the Annual Meeting. This function has the complete support and encouragement of the FMA and all women M.D.'s are invited to participate.

The dinner will be held Thursday evening, May 8th in the Embassy Room at the Diplomat Hotel with cocktails (cash bar) at 6:00 p.m. and dinner at 7:00 p.m. The cost is $25 per person. If you would like to participate, please send your check and reservation directly to Dr. Charlotte H. Kerr, 9675 Seminole Boulevard, Suite E, Seminole, Florida 33542.

Scientific and Educational Exhibits

Convention Hall

May 8 - 10, 1980

A	"Minilaparotomy: A Variation for Tubal Sterilization" — Pierre J. Bouis Jr., M.D., Department of Obstetrics and Gynecology, University of South Florida College of Medicine, Tampa.
B	"Origin, Detection, and Treatment of Colon Polyps and Cancer" — John P. Christie, M.D., Medical Education Foundation of Miami, Inc., Miami.
C	"Continuing Medical Education in Family Practice" — Frederick Firestone, M.D., Department of Family Medicine, University of South Florida College of Medicine, Tampa.
D-E	"The Scope of Plastic Surgery and the Rejuvenation of the Aging Face" — S. Anthony Wolfe, M.D., Florida Society of Plastic and Reconstructive Surgery, Miami.
F	"The Clinical Usefulness of the 24-Hour EEG Monitor" — Wayne E. Tobin, M.D., and others, Miami.
G	"Epidural Venography — The Case of the Hidden Disc" — Stewart Roy Bakst, M.D., and others, Department of Radiology, Palmetto General Hospital, Hialeah.
H	"Compartment Syndromes" — William E. Burkhalter, M.D., American Society for Surgery of the Hand, Miami.
J	"High Level Wellness and Self Care" — Robert D. May, M.D., Pasco County Health Department, New Port Richey.
K	"Immunodiagnosis of Malignancy" — Burton Feinerman, M.D., Miami.
L	"Diagnosis and Surgical Management of Left Main Coronary Artery Disease" — R. Vijayanagar, M.D., and others, Tampa.
M	"Congenital Hypertrophic Pyloric Stenosis" — Bradley M. Rodgers, M.D., Departments of Surgery

and Pediatrics, University of Florida College of Medicine, Gainesville.

N-O "Operative Mitral Valve Disease" — James R. Jude, M.D., and others, North Ridge General Hospital Cardiovascular and Pulmonary Educational and Research Foundation, Inc., Fort Lauderdale.

P "Tc-99m Pertechnetate Scrotal Imaging In Pediatrics" — George N. Sfakianakis, M.D., and J. P. Smith, M.D., Florida Association of Nuclear Physicians, Miami.

Q "Renal Anatomy and Function in Pediatric Nuclear Medicine" — George N. Sfakianakis, and E. Sfakianakis, M.D., Florida Association of Nuclear Physicians, Miami.

R "Closed Intramedullary Fixation of the Femur — A Feasible Procedure in the Community Hospital Setting" — Raymond Bellamy, M.D., Tallahassee.

S "Radiologic Signs of Appendicitis" — John P. Fotopoulos, M.D., Department of Radiology, University Hospital, Jacksonville.

T "Hair Transplant Update 1979 and Classification Male Pattern Baldness" — John W. Devine Jr., M.D., and others, Division of Plastic Surgery, University of Miami School of Medicine, Miami.

U "Sarcoidosis — Still an Enigma" — David F. Bew, M.D., Department of Radiology, University Hospital of Jacksonville.

V-W "Glaucoma Today" — William E. Layden, M.D., National Society to Prevent Blindness, Florida Affiliate; and Department of Ophthalmology, University of South Florida College of Medicine, Tampa.

X, Y, Z, AA, BB, CC, DD & EE Programmed Instruction / Wyeth AutoTutors

GG-FF "Classics in Cardiology — An Art Gallery" — Ali R. Ghahramani, M.D., and others, North Ridge General Hospital Heart Foundation, Fort Lauderdale.

HH "Transplantation in Florida" — The Four Transplant Centers of Florida (Gainesville, Orlando, Tampa and Miami).

JJ "Surgical Management of the Small Aortic Annulus" — Dennis F. Pupello, M.D., and others, Tampa.

KK "Blood Conservation" — Joseph C. Flynn, M.D., and others, Harry Anna Crippled Children's Hospital, Orlando.

Foyer 1 "Florida Academy of Physician Assistants" — Randy Bennett, PA-C, and others, Gainesville.

Foyer 2 "The American Association of Medical Assistants" — Stephanie A. Fischer, CM-A, and others, American Association of Medical Assistants — Florida State Society, Palm Springs.

Foyer 3 "Networks: A Peer Support Model" — Ms. Carole Kinder, Florida Mental Health Institute, Tampa.

Foyer 4 "Trans Patellar Tendon Arthroscopy of the Knee" — Richard G. Onkey, M.D., Naples.

Foyer 5 "An Anti-Smoking Approach for Practicing Physicians" — Lotti Bates, M.D., Indianapolis, Ind.

Foyer 6 "A Prostetic Urinary Bladder" — Norman L. Block, M.D., and others, University of Miami School of Medicine, Miami.

Mrs. Louise Rader, JFMA Managing Editor Retires After 26 Years

The retirement of Mrs. Louise Rader from the FMA staff after more than a quarter century of service has been announced by Executive Vice President W. Harold Parham, D.H.A.

Mrs. Rader joined the FMA staff on September 20, 1954, planning to stay for about two years. Her retirement was effective April 1, 1980.

For many years, Mrs. Rader, a native of Anna, Illinois, has served as Managing Editor of *The Journal*. This April issue on Physical Fitness is the final number to be published under her supervision.

Dr. Parham announced the appointment of Mrs. Susan Love Milhoan, 29, as Mrs. Rader's successor. A native of Evanston, Illinois, Mrs. Milhoan joined the FMA staff in 1977 as Assistant Director of the Public Relations Department. In recent months she has understudied Mrs. Rader.

Both Mrs. Milhoan and her husband, Philip, are graduates of West Virginia University in Morgantown, W.Va.

THE FLORIDA CAMP FOR CHILDREN AND YOUTH WITH DIABETES, INC.

announces its 19th annual summer camp session for youth ages 7-20 years with diabetes.

Dates: June 15th - 28th

Location: Camp Lake Swan
Melrose, Florida

Fee: $200 — Some Camperships are available depending on family need.

Health professionals are invited to attend as participants or just to visit the camp. College age young adults are welcome as counselors.

For further information contact the camp office:

P. O. Box 14136
University Station
Gainesville, Florida 32604
(904) 392-4193 or 6454



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Florida Medical Association Auxiliary, Inc.

FOURTEENTH ANNUAL BENEFIT ART SHOW

Exhibit Rules and Regulations

Read Rules Carefully

1. All entries must be original work.
2. Pictures must be framed and wired for hanging. (Stands will be provided for sculpture, etc.)
3. Each entry must have a typed card indicating Name, Address, Medium, Dimensions and Title. Please list price if entry is for sale; otherwise, mark not for sale (NFS).
4. Only one artist's name should be listed for each registration slip.
5. A registration fee of $10 will be charged for each entry. Entry fees are tax deductible.
6. All registration slips and checks must be sent in together no later than April 23, 1980.
7. All pre-registered entries are to be delivered by hand to the Exhibit Hall at the Diplomat Hotel no later than 3:00 p.m. Wednesday, May 7. Shipped entries will be refused.
8. All entries must remain on exhibition until noon Saturday, May 10. They MUST be picked up between noon and 1:00 p.m., Saturday.
9. We will not be responsible for entries not picked up by 1:00 p.m., Saturday, May 10, 1980.
10. Doctors, their wives and children are eligible to enter. Entry fees will be donations to AMA-ERF, divided equally among Florida medical schools.

Kindly enter my registration to show in the Benefit Art Show.

Fee of $ _____ for _____ entries is enclosed. I agree to abide by the rules and regulations for exhibiting material in the show.

Name _____

Address _____

City _____ County _____

I will be showing in the following categories: Please check (X) appropriate category (categories) applying to your entry (entries).

( ) A. Painting. Include any media in color: acrylic, oil, casein, collage, watercolor, pastel, etc.

Size: _____ (H) x _____ (W) To be hung on wall.

( ) B. Graphics. Include a pen and ink, charcoal, photography, etc.

Size: _____ (H) x _____ (W)

( ) C. Crafts. Include sculpture, pottery, ceramics, mosaic, weaving, jewelry, etc.

Size: _____ (L) x _____ (D) x _____ (H)

( ) I am the son/daughter of a Florida physician. Age _____

Judges will give "Awards of Merit" and "Best in Show." An "Editor's Award," given by the Journal of the Florida Medical Association, will be used on the cover of a future issue of the FMA Journal.

A registration fee of $10 will be charged for each entry. Make checks payable to:

FMA-A Art Show
c/o Mrs. Carlos G. Llanes
11225 S.W. 58th Court
Miami, Florida 33156

NOTE: It is most important to know the size of your art objects, paintings, etc., to enable us to display them more professionally. We will not be responsible for damage or loss of any entry.

REGISTRATION DEADLINE APRIL 23, 1980.

Judging will take place beginning at 9:00 a.m. on Thursday, May 8, 1980.



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Ascorbic Acid	100 mg.
Thiamine HCL	25 mg.
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WARNING: Overdosage may cause muscle tremor and convulsions.

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Books Received

Receipt of the following books is acknowledged. Medical readers interested in reviewing particular books are invited to address requests to the Book Review Editor. Following acceptance of a written review for publication, a reviewer may then retain the book reviewed for his personal or favorite library.

The Chemistry of Human Behavior by Herbert L. Meltzer, Ph.D. 261 Pages. Illustrated. Price $17.95 (cloth). Nelson-Hall Publishers, Chicago, 1979.

Annual Review of Neuroscience with 31 contributing authors. 555 Pages. Annual Reviews, Inc., Palo Alto, California, 1979.

Norethindrone, The First Three Decades edited by Mary Jean Pramik. 100 Pages. Syntex Laboratories, Palo Alto, California, 1978.

Family Health in an Era of Stress conducted by Yankelovich, Skelly and White, Inc. 192 Pages (plus packet). General Mills, Inc., Minneapolis, Minnesota, 1979.

Review of Allied Health Education: 3, Joseph Hamburg, General Editor. 161 Pages. Price $7.50. The University Press of Kentucky, Lexington, Ky., 1979.

How To Improve Your Child's Behavior Through Diet by Laura J. Stevens and Rosemary B. Stoner. 346 Pages. Price $9.95. Doubleday & Company, Inc., New York, 1979.

Helping Hospital Trustees Understand Physicians by Richard E. Thompson, M.D. 82 Pages. Price $9.00. American Hospital Association, Chicago.

Child Guidance by Samuel Kahn, M.D., Ph.D., F.R.S.H. 134 Pages. Price $10.00. Philosophical Library, Inc., New York, 1979.

The Vitamin Book by Rich Wentzler. 224 Pages. Price $4.95. Doubleday & Company, Inc., New York, 1979.

The Truth About Senility — And How To Avoid It by Lawrence Galton. 244 Pages. Price $9.95. Thomas Y. Crowell Company, New York, 1979.

Drug Induced Nutritional Deficiencies by Daphne A. Roe, M.D. 272 Pages. The Avi Publishing Company, Inc., Westport, Connecticut, 1978.

Alcohol and the Diet by Daphne A. Roe, M.D. 229 Pages. The Avi Publishing Company, Inc., Westport, Connecticut, 1979.

Cooking Creatively for Your Diabetic Child by Caroline Hastings Babington. 224 Pages. Price $8.95. Doubleday & Company, Inc., New York, 1979.

Applied Therapeutics for Clinical Pharmacists, Second Edition, Edited by Mary Anne Koda-Kimble, Pharm. D., Brian S. Katcher, Pharm. D., and Lloyd Y. Young, Pharm. D. 944 Pages. Price $31.50. Applied Therapeutics, Inc., San Francisco, 1978.

Review of Physiological Chemistry by Harold A. Harper, Ph.D., Victor W. Rodwell, Ph.D., and Peter A. Mayes, Ph.D., D. Sc. 702 Pages. Price $14.50. Lange Medical Publications, Los Altos, California, 1977.

Clinical Anxiety/Tension in Primary Medicine: Proceedings of a Colloquium, Washington, D.C., Excerpta Medica, Lawrenceville, N.J.

Current Medical Diagnosis and Treatment by Marcus A. Krupp, M.D. and Milton J. Chatton, M.D. 1116 Pages. Price $19.00. Lange Medical Publications, Los Altos, California, 1980.

Currents in Alcoholism, Vols. 3 and 4. Edited by Frank A. Seixas, M.D. 1099 Pages. Price $31.50 and $26.50. Grune & Stratton, Inc., New York, N.Y.

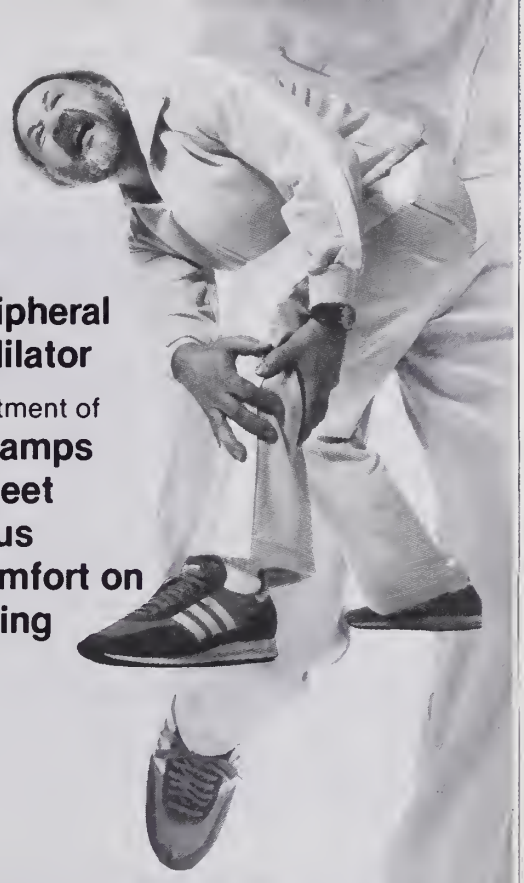
Handbook of Pediatrics by Henry K. Silver, M.D.; C. Henry Kempe, M.D. and Henry B. Bruyn, M.D. 730 Pages. Price $9.50. Lange Medical Publications, Los Altos, California, 1980.

Pharmacological and Toxicological Perspectives of Commonly Abused Drugs from the National Drug Abuse Center, Rosslyn, Virginia.

Handbook of Poisoning, Tenth Edition, by Robert H. Dreisback, M.D. 578 Pages. Price $9.50. Lange Medical Publications, Los Altos, California, 1980.

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Pyridoxine HCL (B-6) .....10 mg.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500.

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Niacinamide .....75 mg.
Ascorbic Acid .....150 mg.
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Riboflavin (B-2) .....2 mg.
Pyridoxine HCL (B-6) .....10 mg.
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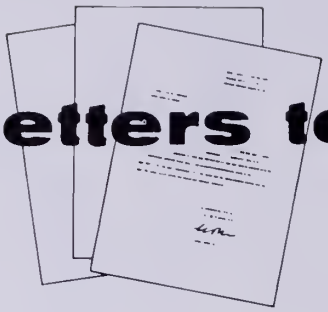
Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur.

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REFE PI



Letters to the Editors

TOP MEDICAL PUBLICATION

Edward D. Hagan, Executive Editor
The Journal of the FMA
Jacksonville

Dear Ed: I was surprised and delighted to receive your welcome letter last week. Thank you for being so thoughtful. I continue to carry extremely fond memories of my visit to you and the Florida State Medical Journal last year. Whenever I reflect upon your generous hospitality at Jacksonville, I experience a gush of pleasure. I was treated graciously at many medical facilities during my year as Morris Fishbein Medical Journalism Fellow, but nothing I received surpassed what I experienced when I was in Florida. Not only is the Florida State Journal among the top medical publications in the country but its staff is wonderful.

Because of your journalistic excellence I have continued to read the Florida Journal to learn how high quality can be achieved. I was pleased to read the report of the visit by Bob Mayo, Jeff Kunz and myself in your June issue. I look forward to seeing future copies of your journal and hope that we can get a chance to visit once again if you are in Connecticut or I am in Florida.

With all best wishes, I am

Yours sincerely,
John P. Callan, M.D.
Hartford, Conn.

(Editor's Note: Dr. Callan was the American Medical Association's Morris Fishbein Medical Journalism Fellow in 1979. As part of his program, he visited with the FMA staff for two days in the company of Mr. Robert Mayo, Executive Editor of *The Journal of the American Medical Association* and Jeff Kunz, M.D., a *JAMA* Contributing Editor).

INTERNATIONAL READERSHIP

To the Editor: Several days ago I was speaking with Dr. Charles Donegan, regarding a very brief article that was published in *The Journal of the Florida Medical Association,* in the June 1979 issue. It concerned an intra-articular accessory sesamoid dislocation of the great toe.

I had considered this a rather rare and miniscule article, but I was pleasantly surprised when I began receiving requests for reprints from Belgium, Czechoslovakia, Chicago, Philadelphia, and other foreign and United States locations. There have been none from Florida so far.

I commented that the journal is certainly having an international readership and Charles thought that you both might be interested in knowing of this response.

Most sincerely,
James C. Barnett, M.D.
St. Petersburg

MARK THESE DATES

ON YOUR CALENDAR . . .

MAY 7-11, 1980

106TH ANNUAL MEETING

FLORIDA MEDICAL ASSOCIATION, INC.

DIPLOMAT HOTEL

HOLLYWOOD-BY-THE-SEA

MEETINGS

Accepted by the FMA Committee on Continuing Medical Education for Mandatory Credit

MAY

Specialized Techniques in Clinical Nutrition, May 1-2, University of South Florida Medical Center Auditorium, Tampa. For information: H. Worth Boyce Jr., M.D., Jay Mamel, M.D., University of South Florida College of Medicine, Box 19, 12901 North 30th Street, Tampa 33612.

Third Annual Gold Coast Seminars; Pelvic Pain and Prenatal Genetic Counseling, May 1-3, Good Samaritan Hospital, Phillips Auditorium, West Palm Beach. For information: John C. Whelton, M.D., Good Samaritan Hospital, Box 3166, West Palm Beach 33402.

Pediatric Ophthalmology, May 1-3, Don CeSar Hotel, St. Petersburg Beach.+

Principles of Cosmetics for the Dermatologist: 1980, May 1-3, Omni International Hotel, Miami. For information: Ms. Esther Cohen, CME Coordinator, Mt. Sinai Medical Center, 4300 Alton Rd., Miami Beach 33140.

Electroencephalogram (EEG) May 5, St. Mary's Hospital, West Palm Beach. For information: Philip Levitt, M.D., 2247 Palm Beach Lakes Boulevard, West Palm Beach 33409.

New Drugs, New Concepts in Clinical Practice, May 6, Holiday Inn, Hollywood Beach. For information: Donald J. Weidler, M.D., Ph.D., Box 016189, Miami, FL 33101.

Scientific Program of the 106th Annual Meeting of the Florida Medical Association, May 7-11, Diplomat Hotel, Hollywood. For information: Calvin W. Martin, M.D., c/o Florida Medical Association, P.O. Box 2411, Jacksonville 32203.

Update on Hormone Replacement, May 12, Citrus Memorial Hospital, Inverness. For information: R. Edward Dodge Jr., M.D., 511 W. Highland Blvd., Inverness 32650.

Designing A Program for the Management of Arthritis, May 13, Manatee Memorial Hospital Auditorium, Bradenton. For information: Leonides Y. Teves, M.D. 706 39th St., W., Bradenton 33505.

Recent Advances in Endocrinology, May 15-17, Hilton Hotel, Jacksonville. For information: Ms. Sheila Reed, CME Coord., JHEP, 655 W. 8th St., Jacksonville 32209.

***For information: Contact Division of Continuing Medical Education, D23-3, University of Miami School of Medicine, P.O. Box 016960, Miami 33101. Tel. (305) 547-6716.**

****For information: Contact Division of Continuing Education, Box J-233, J. Hillis Miller Health Center, Gainesville 32610. Tel. (904) 392-3143, or 392-3183.**

+For information: Contact Janifer M. Judisch, M.D., CME, University of South Florida, Tampa 33620. Tel. (813) 974-2196.

A Symposium: Refracting and Prescribing (Ophthalmology), May 16, Gainesville Hilton, Gainesville.**

Seminar on Hypertension and Renal Disease (in Spanish), May 16-17, Konover Hotel, Miami Beach.*

Persons at High Risk of Cancer: An Approach to Cancer Etiology and Control, May 21, Victoria Hospital, Miami. For information: Peter W. A. Mansell, M.D., Comprehensive Cancer Center D8-4, P.O. Box 016960, Miami 33101.

Annual Meeting — University of Florida Pediatric Alumni Association, May 23-25, Sheraton Palm Coast Resort Inn, Palm Coast. For information: Dale F. Zimmerman, M.D., 1626 Atlantic-University Circle, Jacksonville 32207.

Nuclear Medicine and Radioassay Training Seminar, May 26-30, Miami.*

Master Approach to Cardiovascular Problems — 8th Annual Conference, May 30-June 1, Contemporary Hotel, Disney World, Lake Buena Vista. For information: Yolanda Barcena, Department of Cardiology, P.O. Box 016960, Miami 33101.

JUNE

Bascom Palmer Eye Institute, Resident's Day, June, Miami.*

Annual Homecoming in Psychiatry, June, Miami.*

Cardiology for the Practitioner, June 4-6, The Breakers, Palm Beach.**

31st Annual Scientific Assembly, June 11-15, Marco Beach Hotel, Marco Island. For information: Edwin W. Turner, M.D., c/o Florida Academy of Family Physicians, 4057 Carmichael Avenue, Suite 229, Jacksonville 32207.

Fifth Annual Florida Suncoast Pediatric Conference, June 15-18, Sheraton Sand Key Hotel, Clearwater. For information: Donald I. Macdonald, M.D., 801 Sixth St., S., St. Petersburg 33701.

MKSAP-V (Internal Medicine Review) (American College of Physicians), June 23-27, The Dutch Inn, Lake Buena Vista.**

JULY

Clinical Management of Coronary Disease and Exercise Testing, July 11-13, Orlando Hyatt, Kissimmee. For information: International Medical Education Corp., Division of Postgraduate Education, Dept. 12, 64 Inverness Dr., E., Englewood, Colorado 80112.

Ventricular Arrhythmias, July 14, Citrus Memorial Hospital, Inverness. For information: R. Edward Dodge Jr., M.D., 511 W. Highland Blvd., Inverness 32650.

5th Canadian Summer Workshop in EKG, July 19-22, Edmonton, Alberta, Canada, For information: Henry J. L. Marriott, M.D., Rogers Heart Foundation, St. Anthony's Hospital, St. Petersburg 33705.

Dermatopathology Seminar and Slide Conference, July 26-27, Breaker's Hotel, Palm Beach. For information: C. Fenner McConnell, M.D., 5151 N. 9th Ave., Pensacola 32504.

AUGUST

Fundamental and Clinical Aspects of Internal Medicine, Aug. 1980.*

EKG Interpretation and Arrhythmia Management, Aug. 22-23, Dutch Inn, Lake Buena Vista. For information: International Medical Education Corp., Division of Postgraduate Education, Dept. 12, 64 Inverness Dr., E., Englewood, Colorado 80112.

18th Annual Seminar in Cardiology, Aug. 30-Sept. 6, Copenhagen, Denmark. For information: Henry J. L. Marriott, M.D., Rogers Heart Foundation. St. Anthony's Hospital, St. Petersburg 33705.

SEPTEMBER

Dermatology in Florida, Sept. 8, Citrus Memorial Hospital, Inverness. For information: R. Edward Dodge Jr., M.D., 511 W. Highland Blvd., Inverness 32650.

OCTOBER

Echocardiography In-Service Workshop, Oct. 20-24, University of Miami, Jackson Memorial Medical Center, Miami.*

21st Workshop in EKG for Nurses and Physicians, Oct. 30-Nov. 3, Sheraton Sand Key Hotel, Clearwater Beach. For information: Henry J. L. Mariott, M.D., St. Anthony's Hospital, St. Petersburg 33705.



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POST-GRADUATE SEMINAR

Wednesday
April 30, 1980

"MEDICAL AND CARDIOVASCULAR PROBLEMS IN ORTHOPAEDICS"

8:00 a.m. — 1:00 p.m.

Wolfson Auditorium, Mount Sinai Medical Center of Greater Miami, 4300 Alton Rd., Miami Beach, FL 33140

GUEST FACULTY:

JACK GREENBERG, M.D.
Mount Sinai Medical Center

JOHN JENNINGS, M.D.
Miami, Florida

JOSEPH LANE, M.D.
New York, New York

ROBERT RUBIN, M.D.
Boston, Massachusetts

ARTHUR A. SASAHARA, M.D.
West Roxbury, Massachusetts

PROGRAM DIRECTORS:

MARVIN L. MEITUS, M.D.
CHARLES WEISS, M.D.
Mount Sinai Medical Center of Greater Miami

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Accreditation: Category I — 'Physician's Recognition Award' — 4.5 credit hours.

Registration Fee: $50.

For further information: Continuing Medical Education — Mount Sinai Medical Center, 4300 Alton Rd., Miami Beach, FL 33140, (305) 674-2311.

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2. GRAPHICS — pen and ink, charcoal, photography, etc.
3. CRAFTS — sculpture, pottery, ceramics, mosaic, weaving, jewelry, etc.

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1980 SOUTHEAST EMERGENCY MEDICINE CONGRESS: DeSoto Hilton Hotel, Savannah, Georgia, May 7-9, 1980. Sponsored by 10 southeast chapters of American College of Emergency Physicians and Region IV of Emergency Department Nurses Association. Fees: Physicians $220.00, $190,00 for ACEP members; Nurses $110.00, $75.00 for EDNA members. Contact R. T. Lowry, M.D., 901-D Kildaire Farm Road, Cary, North Carolina 27511. (919) 469-1942.

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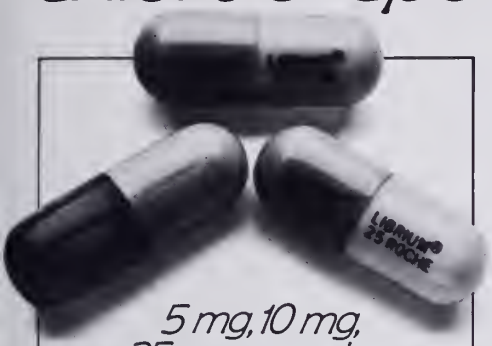
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Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

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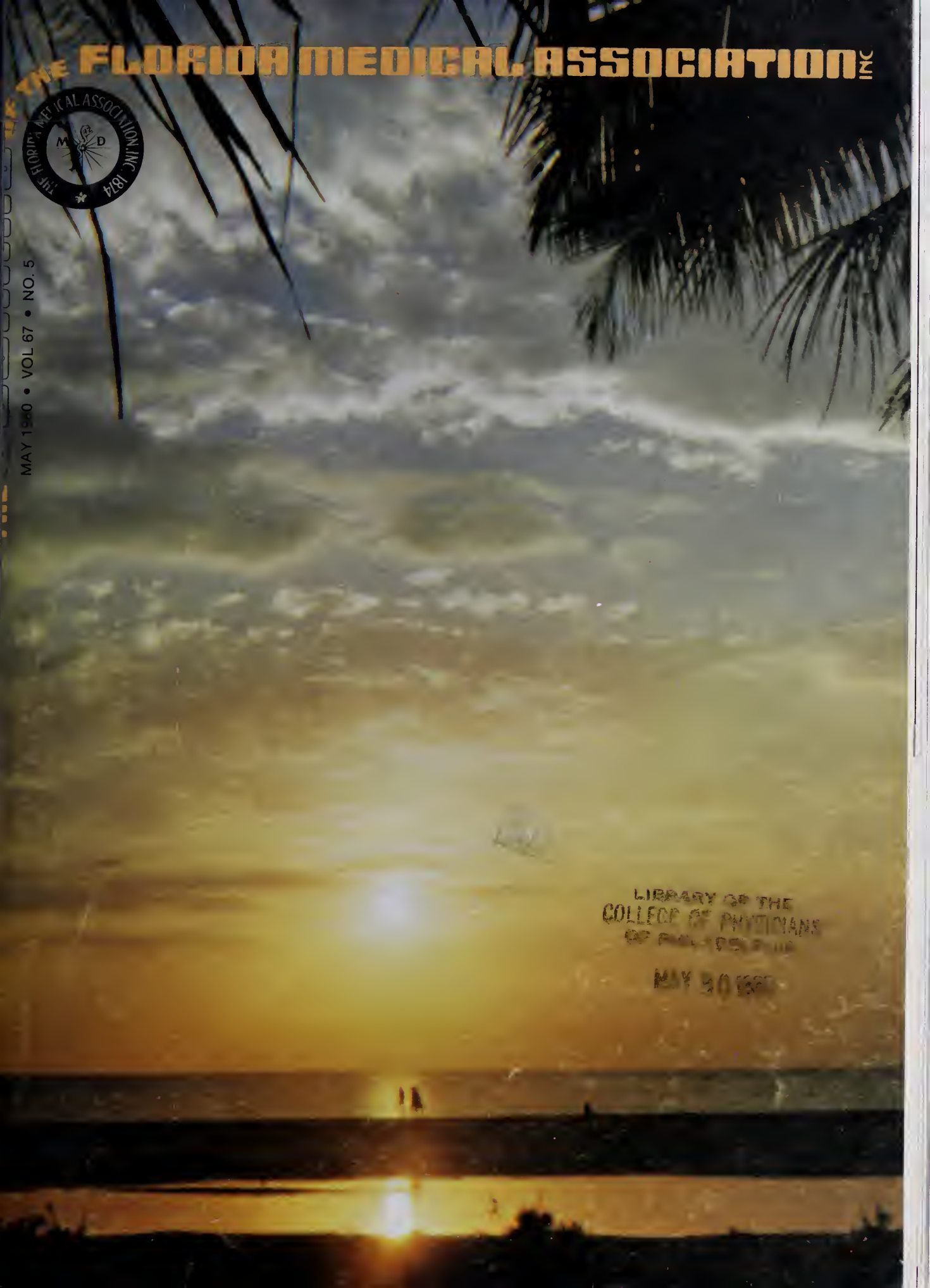


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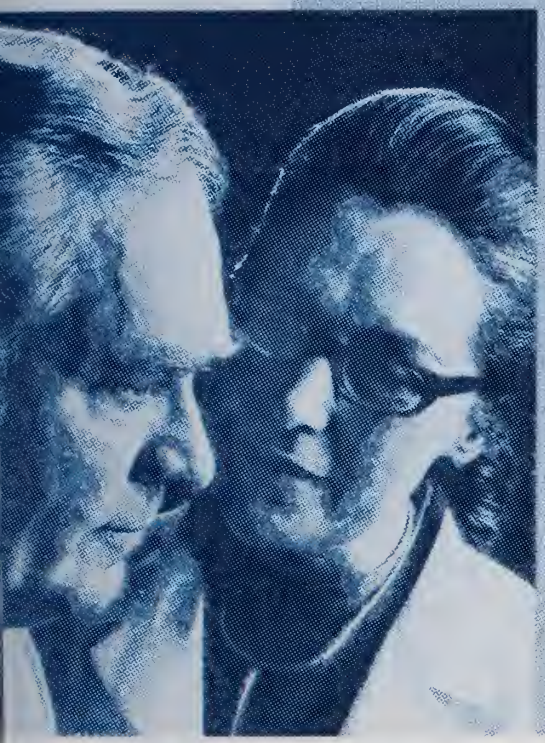

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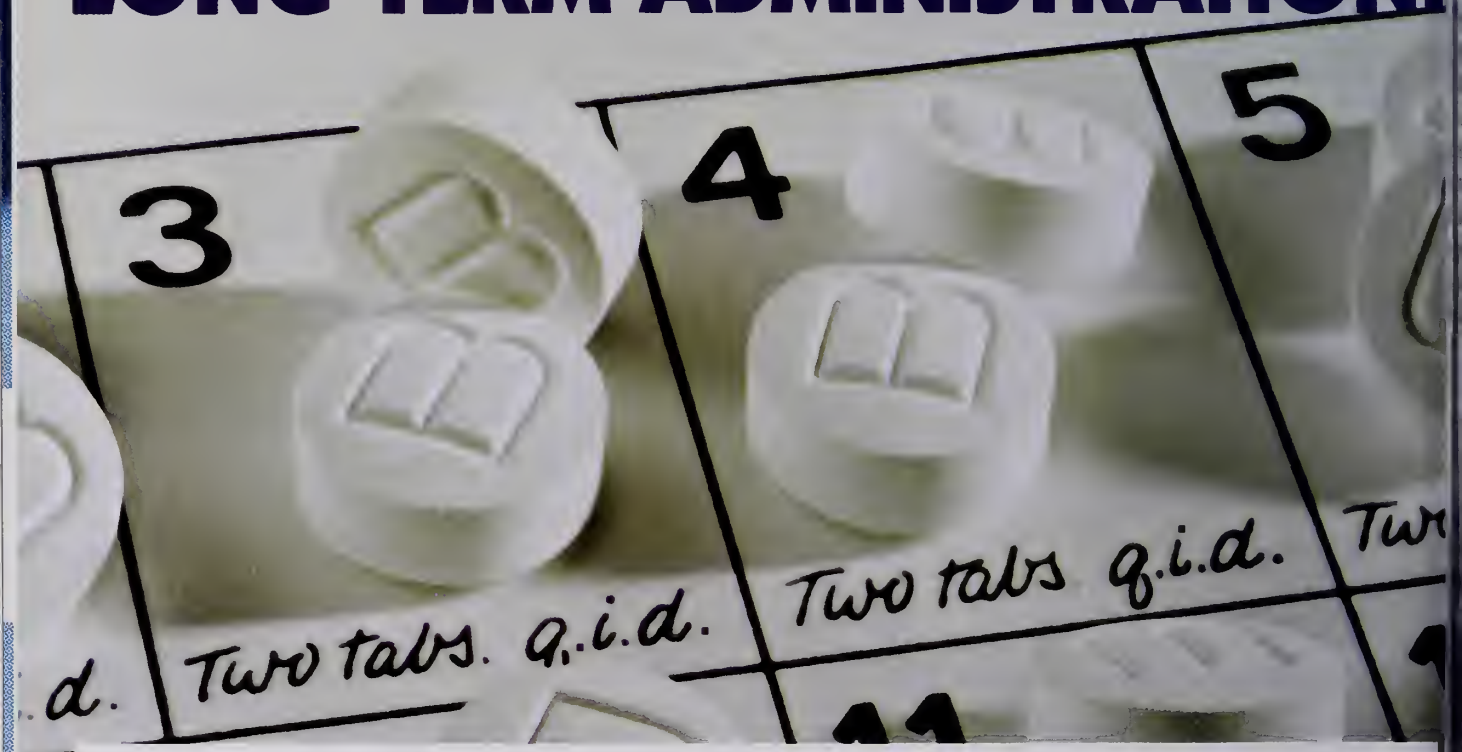
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On the Cover

Sunset at Sanibel Island - A photograph by Richard K. O'Hern, M.D., a practicing pediatrician at Rockledge.

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FROM THE EDITOR'S DESK

VERIFICATION FOR MEDICAID SERVICES

A proposed verification program for Medicaid services contains significant potential for inaccuracy, the AMA told the Health Care Financing Administration. The proposal would dictate that notices containing items to be verified be sent to Medicaid recipients within 45 days of the claim date. Failure to respond within 30 days would initiate agency follow-up, and discrepant responses would initiate agency investigation. "The proposed regulations may significantly increase administrative cost without an equally significant gain in fraud or abuse detection and conviction," the AMA commented.

HEW BUDGET CUT

HEW appropriations are expected to be cut by $700 million as part of the Carter Administration's program to balance the federal budget. Ninety percent of the HEW cut will come from the Public Health Service. Hardest hit is the National Institutes of Health, which will lose $350 million.

VA PHYSICIAN COMPENSATION

The AMA has told the House Subcommittee on Medical Facilities and Benefits that compensation for VA physicians should be comparable with those received by physicians in other government services. Any substantial difference in compensation could result in self-defeating competition and recruitment. The testimony was offered in an effort to make permanent the VA Physician and Dentist Pay Comparability Act.

FTC CLOSES INVESTIGATION OF ASPRS

The FTC has abandoned its three-year investigation of the American Society of Plastic and Reconstructive Surgeons for alleged restraint of trade through the use of misleading statements about the practice of plastic surgery. The FTC decided to close the case "because the commission could not be put in the position of apparently trying to decide issues of medical competence...of appearing to jeopardize quality," according to a spokesman.

FUNDING MEDICAL EDUCATION

The AMA has warned Congress of the dangers of withdrawing or reducing federal government support of medical education. Senior Vice President C. H. William Ruhe, M.D., told the Senate Human Resources Subcommittee that loss of general institutional support would cause schools to seek other sources of funds, possibly through tuition increases, and harm the quality and availability of medical education. Noting that legislation has been introduced to modify the current capitation program by establishing "national priority incentive grants," Dr. Ruhe said such a program would make funds to schools conditional on specific curricula and student census criteria. Medical schools, he said, are being asked to control the actions of their graduates.

BOARD CERTIFICATION AND FMG'S

Proposed amendments to the Immigration and Nationality Act will eliminate the requirement that foreign medical graduates obtain Board Certification to maintain their immigrant status. The proposal will also exempt FMG's from taking the Visa Qualifying Exam if they were licensed and practicing before 1977.

REGULATING THE NUMBER OF PHYSICIANS

Any efforts to regulate the number of physicians, their specialties and their practice locations are "incompatible with the principles of a free society and the rights of individuals to choose their occupations and their place of residence," the AMA told the Human Resources Committees of the National Governors' Association and the National Conference of State Legislatures. According to the AMA, such efforts are increasing, and if successful will result in a reduction in the availability and quality of medical care.

NHI CAUGHT IN BUDGET SQUEEZE

Some members of the Senate Finance Committee are now contending that the budget squeeze is so serious that all NHI legislation should be shelved for this year. Chairman Russell Long (D-La.) wants the committee to approve a catastrophic plan, stating that only modest start-up costs would be needed next year.

ANTITRUST VIOLATION CHARGES DISMISSED IN NEW YORK

Charges that the AMA and 13 other defendants violated New York antitrust laws have been dismissed by a Federal District Court judge. The suit, filed last summer by New York State, charged that a "group boycott" prevented chiropractors from competing effectively and caused New Yorkers to pay higher costs for health care. The judge ruled that New York antitrust laws do not apply to the medical profession. Charges that the defendants violated federal antitrust laws are still before the court.

The Editor





Dr. Palmer

George S. Palmer, M.D. ... Executive Director of the Florida State Board of Medical Examiners for the past 10 years, has accepted another position with the State.

Dr. Palmer has become Medical Consultant for the Florida Department of Professional Regulation, parent agency of the Board of Medical Examiners. His duties will include reviewing health-related complaints received by the Department, reviewing applications for limited licenses and serving as liaison with hospitals, health care agencies, the Florida Medical Association and other health-related professional organizations.

Until the late 1960s, Dr. Palmer practiced pediatrics in Tallahassee. He is a Past President of the Florida Medical Association.

Twenty-three Florida physicians . . . are among the latest group of 360 physicians elected nationally to Fellowship in the American College of Cardiology. It was the largest group ever to be admitted to Fellowship at any one time.

The new Florida Fellows are:

Alfred J. Alvarez, M.D., Edgardo R. Dos Santos, M.D. and **Jorge A. Flores, M.D.**, all of Fort Lauderdale; **Robert B. Boswell, M.D.**, Orlando; **Joseph M. Cherian, M.D.**, Milton; **Clifford D. Colin, M.D.**, New Port Richey; **Edward Cutler, M.D., Robert H. Karl, M.D., Robert H. Kirstein, M.D.**, and **Jay Midwall, M.D.**, all of Miami; and **Lawrence J. Jacobs, M.D.**, Hollywood.

Michael J. King, M.D., and **Neil S. Schneider, M.D.**, both of Miami Beach; **Humberto Machado, M.D.**, Hialeah; **Brian D. Remington, M.D., Allan Schonberg, M.D.**, and **William G. Short, M.D.**, all of Jacksonville; **Asis K. Saha, M.B.B.S.**, Kissimmee; **Josie E. Seco, M.D.**, Maitland; **William M. Sherman, M.D.**, Margate; **George Thomas, M.B.B.S.**, Bradenton; **Edward C. Ziegler, M.D.**, Cape Coral; and **Edgar H. Willard III, M.D.**, Winter Haven.

Donald V. Eitzman, M.D., of Gainesville . . . has been elected President of the Southern Perinatal Association. Dr. Eitzman, Professor of Pediatrics and Chief of the Division of Neonatology at the University of Florida College of Medicine, was Vice President of the Association in 1979.

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Professional Liability Legal Update

Successful Physician's Countersuit Reversed

This was an action brought by Dr. John Sullivan against his former patient, James Terry, and the patient's lawyers, the firm of Fee, Parker & Lloyd, P.A., and Otis Parker, individually. Dr. Sullivan alleged that Terry and Parker had maliciously prosecuted a medical malpractice action against him based upon his treatment of Terry. The medical malpractice action was voluntarily dismissed prior to trial, and Dr. Sullivan sued the patient and his lawyer contending that they did not have probable cause to sue him for medical malpractice. The jury returned a verdict in favor of Dr. Sullivan in the amount of $175,000 against the lawyer and his law firm and found that patient not liable. After the trial court ordered a remittitur of $100,000, final judgment was entered for Dr. Sullivan in the amount of $75,000, plus costs against Parker and his firm. An appeal was taken from that judgment.

At the outset, the Court noted that in order to prevail in a malicious prosecution action, the plaintiff must prove: (1) the commencement or continuation of an original civil or criminal proceeding; (2) its legal causation by the present defendant against the plaintiff; (3) its termination in favor of the plaintiff; (4) the absence of probable cause for such prosecution; (5) the presence of malice; and (6) damages resulting to the plaintiff.

The thrust of the argument by the patient and his attorney was that the evidence presented at trial was insufficient to establish the elements of a malicious prosecution action. In particular, it was argued that Dr. Sullivan failed to prove that appellants lacked probable cause for commencing the malpractice action.

In speaking of the standards to be applied in a malicious prosecution action, the Court recognized that public policy encourages the settlement of private disputes through access to the courts. Such access, however, is not without limitation. When the courts are used to promote an unjustifiable cause, an injustice is imposed upon one's adversary whose only resource is to sue the offending party for malicious prosecution.

The Court expressed its opinion that a lawyer must represent his client zealously within the bounds of the law and professional ethics. As an advocate he must accept the facts as he finds them and render his advice consistent with those facts and his knowledge of the law. He is therefore charged with making a reasonable investigation and determining the facts before initiating a suit on his client's behalf. If he then has a reasonable, honest belief that his client has a tenable claim, he enjoys the same freedom of access to the court as does his client. Any more stringent standard would effectively stifle the peaceful resolution of disputes and deny the very justice the courts are intended to administer. The Court also agreed with a California decision which held that so long as an attorney does not abuse the duty to represent his client by prosecuting a claim which a reasonable lawyer would not regard as tenable or by unreasonably neglecting to investigate the facts and the law in making is determination to proceed, his client's adversary has no right to assert a malicious prosecution action against the attorney if the lawyer's efforts prove unsuccessful.

Against this background, the Court reviewed the evidence presented to it on appeal. The evidence presented showed initial, questionable treatment by the performance of a closed reduction of a Monteggia fracture without adequate follow-up x-rays. The closed reduction was unsuccessful, necessitating an open reduction and rod insertion. The doctor admitted he measured the rod incorrectly, and that he was further incorrect in not taking x-rays. He also admitted he deliberately kept these facts out of the hospital records because they were damaging. When later x-rays showed the rod protruding into the wrist, further surgery to shorten it was performed almost six weeks later. This further surgery, necessitated solely by the doctor's admitted prior errors in treatment, was also unsuccessful. Finally, the patient went to another doctor who did still another surgical procedure and corrected the prior medical errors. The patient also visited a lawyer who conferred with the latter doctor and with the patient and reviewed records and x-rays. Correspondence to the doctor about the problem resulted in settlement negotiation with the doctor's insurance company.

Prepared and submitted by John E. Thrasher, J.D., Vice President and Legal Counsel, and Anthony J. McNicholas III, J.D., Associate Legal Counsel, Professional Insurance Management Co. (PIMCO), Jacksonville, Fla.

Based upon these facts, the Court reversed the judgment in favor of Dr. Sullivan holding that "a manifest miscarriage of justice would occur were we to hold these facts, as provided by plaintiff, supportive of an absence of probable cause to believe the doctor was actually guilty of malpractice as a matter of law, however, we do find that the evidence proved the existence of, rather than the absence of, probable cause."

Thus, in the final analysis, although the Court held that an attorney must make an investigation of the facts of a claim, and having done that, still cannot file a suit which "a reasonable lawyer would not regard as tenable," it reversed the judgment in favor of Dr. Sullivan because it felt that the admitted facts in this case demonstrated that there was probable cause to believe that medical malpractice had occurred. *Fee, Parker & Lloyd, P.A. v. Sullivan,* So.2d 412 (Fla. D.C.A. 1980).

Our great business in life is not to see what lies dimly at a distance, but to do what lies clearly at hand.

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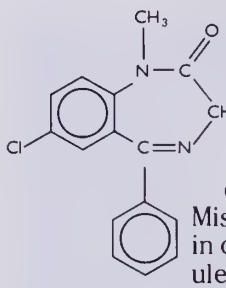
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Your patients should know that 1) you are prescribing Valium as an adjunct to an overall program for the treatment of anxiety, and 2) Valium is given to relieve the symptoms of excessive anxiety and psychic tension while you help the patient to explore and deal with the underlying cause of his psychic tension.

Patients often interpret manifestations of anxiety, such as palpitations, hyperventilation, fatigue and muscle tension, as symptoms of a serious disease. However, when they learn that these symptoms can be relieved by Valium therapy, patients can more readily understand the psychosomatic origin of their symptoms and to accept the nonpharmacologic measures you may recommend.

The time you devote to these explanations can be a therapeutic measure in itself. Most anxious patients respond to and benefit from a frank discussion with an objective, sympathetic professional.

At the start of treatment, establishing therapeutic goals helps the patient to learn *what* to expect and *when* to expect it. Patients should also be informed that the medication will be gradually reduced and discontinued upon attainment of the therapeutic goal.

Tapering of dosage is rarely necessary in short-term therapy, but when consistently higher doses are used for extended periods, patients should know that the gradual reduction of medication will be implemented in order to avoid sudden recurrence of symptoms or possible withdrawal symptoms. Such recurrence is unlikely when the causes of the anxiety have been worked out satisfactorily within your overall treatment program.



What Valium (diazepam/Roche) can't do

It should be emphasized that there is no "magic" in any antianxiety tablet; that medication is not prescribed as a problem solver. Instead, Valium is being prescribed *as a temporary measure to relieve symptoms* generated by excessive anxiety and psychic tension.

* Boyd JR, *et al*: *Am J Hosp Pharm 31*: 485-491, May 1974

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Indications: Tension and anxiety associated with anxiety disorders, transient situational disturbances and functional or organic disorders, psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms, or agitation, symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal, adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).
The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication, abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. drugs such as phenothiazines, narcotics,



Practical pointers on taking antianxiety medications

do's Patients should be instructed to keep to their dosage schedule exactly as prescribed. If they miss a dose, they should not try to make it up by taking two doses the next time. Ask them to contact you promptly if they experience worrisome side effects. Explain that drowsiness is a common reaction to almost all calming agents, but that it usually subsides in a few days. Urge the patient to contact you for a possible dosage adjustment if drowsiness or other reactions persist.

Just as you request a complete list of all medications the patient is taking, suggest that this list be given to any other physician treating her/him.

Like all medicines, Valium should be kept out of reach of children and young people. Old or unused medication should be discarded.

and don'ts Since drowsiness is an occasional problem, patients should be advised against driving or operating hazardous machinery until they see how the medication affects them. They should also know that tranquilizers increase the effects of alcoholic beverages, which should therefore be avoided. Also, warn patients against simultaneous use of drugs that depress the central nervous system, particularly sedative hypnotics.

Patients should be aware of the importance of not sharing their medications with friends and neighbors; they should know that what you have prescribed for them may be contraindicated for others.

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Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea,
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inence, changes in salivation, slurred speech, tremor, vertigo, urinary retention,
d vision. Paradoxical reactions such as acute hyperexcited states, anxiety,
inations, increased muscle spasticity, insomnia, rage, sleep disturbances,
ation have been reported, should these occur, discontinue drug. Isolated reports
lropenia, jaundice, periodic blood counts and liver function tests advisable
long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults.* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d., alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed, adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d., adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated (See Precautions.) *Children* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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Protein	100	100	80
Phosphorus	100	85	85
Vitamin B_6	76	51	34
Vitamin D	75	75	75
Niacin*	71	63	47
Thiamin	56	40	31
Vitamin A	46	46	37

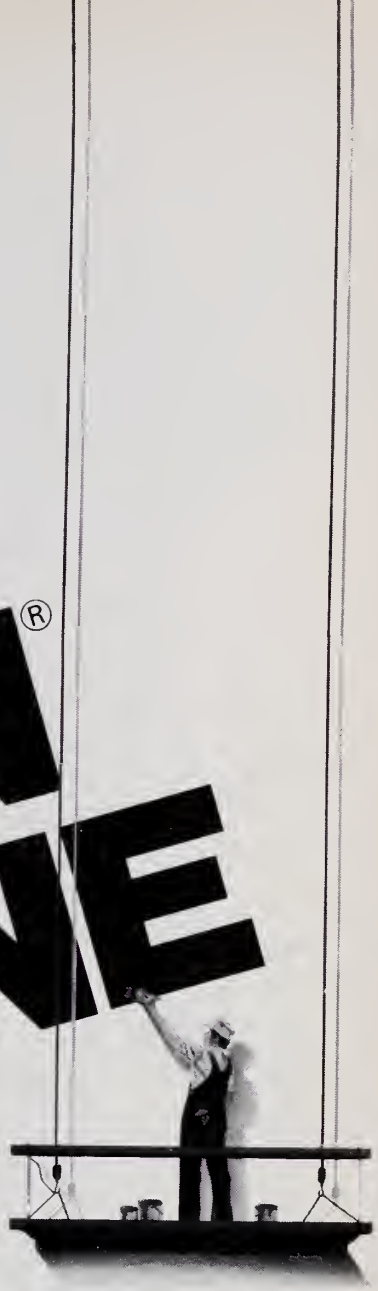
*maximum niacin equivalents based on: 60 mg tryptophan=1 mg niacin

ndc **National Dairy Council**

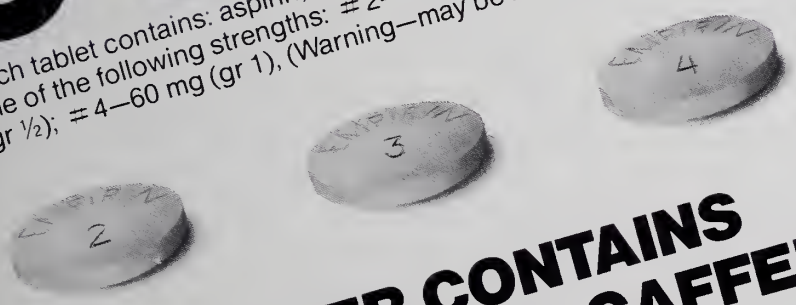
Milk. Sometimes we forget all the good things it does.

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EMPIRIN® C CODEINE



Each tablet contains: aspirin, 325 mg; plus codeine phosphate in one of the following strengths: ≠2—15 mg (gr ¼); ≠3—30 mg (gr ½); ≠4—60 mg (gr 1), (Warning—may be habit-forming)



NO LONGER CONTAINS PHENACETIN OR CAFFEINE.

ONE HUNDRED YEARS WELLCOME

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709


getting back
to business

with symptomatic relief of moderate anxiety with depression

Rapid relief of anxiety

The tranquilizer component alleviates symptoms of anxiety within a few days without apparent dulling of mental acuity. Hypnotic effects appear to be minimal, particularly in patients permitted to remain active. However, TRIAVIL may impair mental and/or physical abilities required for the performance of hazardous tasks.

Dependable antidepressant action

The antidepressant component relieves symptoms of depression such as poor concentration and feelings of hopelessness as well as early morning awakening; adequate relief of symptoms may take a few weeks or even longer.

for moderate anxiety with depression

dual-action Triavil®

containing perphenazine and amitriptyline HCl

Treatment with TRIAVIL—a balanced view

TRIAVIL is contraindicated in CNS depression from drugs, in the presence of evidence of bone marrow depression, and in patients hypersensitive to phenothiazines or amitriptyline. It should not be used during the acute recovery phase following myocardial infarction or in patients who have received an MAOI within two weeks. Patients with cardiovascular disorders should be watched closely. Not recommended in children or during pregnancy. TRIAVIL may enhance the response to alcohol. Antiemetic effects may obscure toxicity due to overdosage of other drugs or mask other disorders. The possibility of suicide in depressed patients remains until significant remission occurs. Such patients should not have access to large quantities of the drug. Hospitalize as soon as possible any patient suspected of having taken an overdose.

MSD
MERCK SHARP & DOHME

Please see the following page for a brief summary of prescribing information.

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by providing symptomatic relief of moderate anxiety with depression

dual-action Triavil®

containing perphenazine and amitriptyline HCl

helps patients get back to business

Available:
TRIAVIL® 2-25: Each tablet contains
2 mg perphenazine and 25 mg amitriptyline HCl.
TRIAVIL® 2-10: Each tablet contains
2 mg perphenazine and 10 mg amitriptyline HCl.
TRIAVIL® 4-50: Each tablet contains
4 mg perphenazine and 50 mg amitriptyline HCl.
TRIAVIL® 4-25: Each tablet contains
4 mg perphenazine and 25 mg amitriptyline HCl.
TRIAVIL® 4-10: Each tablet contains
4 mg perphenazine and 10 mg amitriptyline HCl.

CONTRAINDICATIONS: Central nervous system depression from drugs (barbiturates, alcohol, narcotics, analgesics, antihistamines); evidence of bone marrow depression; known hypersensitivity to phenothiazines or amitriptyline. Should not be given concomitantly with a monoamine oxidase inhibitor since hyperpyretic crises, severe convulsions, and deaths have occurred from such combinations. When used to replace a monoamine oxidase inhibitor, allow a minimum of 14 days to elapse before initiating therapy with TRIAVIL. Therapy should then be initiated cautiously with gradual increase in dosage until optimum response is achieved. Not recommended for use during acute recovery phase following myocardial infarction.

WARNINGS: TRIAVIL should not be given concomitantly with guanethidine or similarly acting compounds since TRIAVIL may block the antihypertensive action of such compounds. Use cautiously in patients with history of urinary retention, angle-closure glaucoma, increased intraocular pressure, or convulsive disorders. Dosage of anticonvulsive agents may have to be increased. In patients with angle-closure glaucoma, even average doses may precipitate an attack. Patients with cardiovascular disorders should be watched closely. Tricyclic antidepressants, including amitriptyline HCl, have been reported to produce arrhythmias, sinus tachycardia, and prolongation of conduction time, particularly in high doses. Myocardial infarction and stroke have been reported with tricyclic antidepressant drugs. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. May impair mental and/or physical abilities required for performance of hazardous tasks, such as operating machinery or driving a motor vehicle. In patients who use alcohol excessively, potentiation may increase the danger inherent in any suicide attempt or overdosage. Not recommended in children or during pregnancy.

PRECAUTIONS: Suicide is a possibility in depressed patients and may remain until significant remission occurs. Such patients should not have access to large quantities of this drug.

Perphenazine: Should not be used indiscriminately. Use with caution in patients who have previously exhibited severe adverse reactions to other phenothiazines. Likelihood of some untoward actions is greater with high doses. Closely supervise with any dosage. The antiemetic effect of perphenazine may obscure signs of toxicity due to overdosage of other drugs or make more difficult the diagnosis of disorders such as brain tumor or intestinal obstruction. A significant, not otherwise explained, rise in body temperature may suggest individual intolerance to perphenazine, in which case discontinue.

If hypotension develops, epinephrine should not be employed, as its action is blocked and partially reversed by perphenazine. Phenothiazines may potentiate the action of central nervous system depressants (opiates, analgesics, antihistamines, barbiturates, alcohol) and atropine. In concurrent therapy with any of these, TRIAVIL should be given in reduced dosage. May also potentiate the action of heat and phosphorous insecticides. There is sufficient experimental evidence to conclude that chronic administration of antipsychotic drugs which increase prolactin secretion has the potential to induce mammary neoplasms in rodents under the appropriate conditions. There are recognized differences in the physiological role of prolactin between rodents and humans. Since there are, at present, no adequate epidemiological studies, the relevance to human mammary cancer risk from prolonged exposure to perphenazine and other antipsychotic drugs is not known.

Amitriptyline: In manic-depressive psychosis, depressed patients may experience a shift toward the manic phase if they are treated with an antidepressant. Patients with paranoid symptomatology may have an exaggeration of such symptoms. The tranquilizing effect of TRIAVIL seems to reduce the likelihood of this effect. When amitriptyline HCl is given with anticholinergic agents or sympathomimetic drugs, including epinephrine combined with local anesthetics, close supervision and careful adjustment of dosages are required. Paralytic ileus may occur in patients taking tricyclic antidepressants in combination with anticholinergic-type drugs.

Caution is advised if patients receive large doses of ethchlorvynol concurrently. Transient delirium has been reported in patients who were treated with 1 g of ethchlorvynol and 75-150 mg of amitriptyline HCl.

Amitriptyline HCl may enhance the response to alcohol and the effects of barbiturates and other CNS depressants.

Concurrent administration of amitriptyline HCl and electroshock therapy may increase the hazards associated with such therapy. Such treatment should be limited to patients for whom it is essential. Discontinue several days before elective surgery if possible. Elevation and lowering of blood sugar levels have both been reported. Use with caution in patients with impaired liver function.

ADVERSE REACTIONS: Similar to those reported with either constituent alone.
Perphenazine: Extrapyramidal symptoms (opisthotonus, oculogyric crisis, hyperreflexia, dystonia, akathisia, acute dyskinesia, ataxia, parkinsonism) have been reported and can usually be controlled by the concomitant use of effective antiparkinsonian drugs and/or by reduction in dosage, but sometimes persist after discontinuation of the phenothiazine.

Tardive dyskinesia may appear in some patients on long-term therapy or may occur after drug therapy with phenothiazines and related agents has been discontinued. The risk appears to be greater in elderly patients on high-dose therapy, especially females. Symptoms are persistent and in some patients appear to be irreversible. The syndrome is characterized by rhythmical involuntary movements of the tongue, face, mouth, or jaw. Involuntary movements of the extremities sometimes occur. There is no known treatment for tardive dyskinesia; antiparkinsonism agents usually do not alleviate the symptoms. It is advised that all antipsychotic agents be discontinued if the above symptoms appear. If treatment is reinstituted, or dosage of the particular drug increased, or another drug substituted, the syndrome may be masked. Fine vermicular movements of the tongue may be an early sign of the syndrome. The full-blown syndrome may not develop if medication is stopped when lingual vermiculation appears.

Other side effects are skin disorders (photosensitivity, itching, erythema, urticaria, eczema, up to exfoliative dermatitis); other allergic reactions (asthma, laryngeal edema, angioneurotic edema, anaphylactoid reactions); peripheral edema, reversed epinephrine effect; hyperglycemia; endocrine disturbances (lactation, galactorrhea, gynecomastia, disturbances of menstrual cycle); altered cerebrospinal fluid proteins; paradoxical excitement; hypertension, hypotension, tachycardia, and ECG abnormalities (quinidine-like effect); reactivation of psychotic processes; catatonic-like states; autonomic reactions, such as dry mouth or salivation, headache, anorexia, nausea, vomiting, constipation, obstipation, urinary frequency or incontinence, blurred vision, nasal congestion, and a change in pulse rate; other adverse reactions reported with various phenothiazine compounds, but not with perphenazine, include grand mal convulsions, cerebral edema, polyphagia, pigmentary retinopathy, photophobia, skin pigmentation, and failure of ejaculation.

The phenothiazine compounds have produced blood dyscrasias (pancytopenia, thrombocytopenic purpura, leukopenia, agranulocytosis, eosinophilia) and liver damage (jaundice, biliary stasis).

Pigmentation of the cornea and lens has been reported to occur after long-term administration of some phenothiazines. Although it has not been reported in patients receiving TRIAVIL, the possibility that it might occur should be considered.

Hypnotic effects, lassitude, muscle weakness, and mild insomnia have also been reported.

Amitriptyline: Note: Listing includes a few reactions not reported for this drug, but which have occurred with other pharmacologically similar tricyclic antidepressant drugs and must be considered when amitriptyline is administered. *Cardiovascular:* Hypotension; hypertension; tachycardia; palpitation; myocardial infarction; arrhythmias; heart block; stroke. *CNS and Neuromuscular:* Confusional states; disturbed concentration; disorientation; delusions; hallucinations; excitement; anxiety; restlessness; insomnia; nightmares; numbness, tingling, and paresthesias of the extremities; peripheral neuropathy; incoordination; ataxia; tremors; seizures; alteration in EEG patterns; extrapyramidal symptoms; tinnitus; syndrome of inappropriate ADH (antidiuretic hormone) secretion. *Anticholinergic:* Dry mouth; blurred vision; disturbance of accommodation; increased intraocular pressure; constipation; paralytic ileus; urinary retention; dilatation of urinary tract. *Allergic:* Skin rash; urticaria; photosensitization; edema of face and tongue. *Hematologic:* Bone marrow depression including agranulocytosis; leukopenia; eosinophilia; purpura; thrombocytopenia. *Gastrointestinal:* Nausea; epigastric distress; vomiting; anorexia; stomatitis; peculiar taste; diarrhea; parotid swelling; black tongue. Rarely hepatitis (including altered liver function and jaundice). *Endocrine:* Testicular swelling and gynecomastia in the male; breast enlargement and galactorrhea in the female; increased or decreased libido; elevated or lowered blood sugar levels. *Other:* Dizziness, weakness; fatigue; headache; weight gain or loss; increased perspiration; urinary frequency; mydriasis; drowsiness; alopecia. *Withdrawal Symptoms:* Abrupt cessation after prolonged administration may produce nausea, headache, and malaise. These are not indicative of addiction.

OVERDOSAGE: All patients suspected of having taken an overdosage should be admitted to a hospital as soon as possible. Treatment is symptomatic and supportive. However, the intravenous administration of 1–3 mg of physostigmine salicylate is reported to reverse the symptoms of tricyclic antidepressant poisoning. Because physostigmine is rapidly metabolized, the dosage of physostigmine should be repeated as required particularly if life-threatening signs such as arrhythmias, convulsions, and deep coma recur or persist after the initial dosage of physostigmine. On this basis, in severe overdosage with perphenazine-amitriptyline combinations, symptomatic treatment of central anticholinergic effects with physostigmine salicylate should be considered.

J9TR33 (DC66132

For more detailed information, consult your MSD Representative or see full Prescribing Information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486.

MSD
MERCK SHARP DOHME



A non-narcotic one-two punch against pain, with concurrent relief of anxiety/tension

EQUAGESIC® ℞

meprobamate and ethoheptazine citrate with aspirin) Wyeth

EQUAGESIC—Abbreviated Summary

***INDICATIONS:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified indications as follows.

"Possibly" effective: for the treatment of pain accompanied by tension and/or anxiety in patients with musculoskeletal disease or tension headache.

Final classification of the less-than-effective indications requires further investigation.

The effectiveness of Equagesic in long-term use, i.e., for more than four months, has not been assessed by systematic clinical studies. The physician should periodically reassess usefulness of the drug for the individual patient.

CONTRAINDICATIONS: Equagesic should not be given to patients with a history of sensitivity or severe intolerance to aspirin, meprobamate, or ethoheptazine citrate

WARNINGS: Careful supervision of dose and amounts prescribed for patients is advised, especially with those patients known to have a propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g., addicts, former addicts, and other severe psychoneurotics, has been reported to result in dependence on or habituation to the drug. Where excessive dosage has continued for weeks or months, dosage should be reduced gradually rather than abruptly stopped, since withdrawal of a "crutch" may precipitate withdrawal reaction of greater proportions than that for which the drug was originally prescribed. Abrupt discontinuance of doses in excess of the recommended dose is reported to have resulted in some cases in the occurrence of epileptiform convulsions.

Particular care should be taken to warn patients taking meprobamate that tolerance to alcohol may be lowered with resultant lowering of reaction time and impairment of judgement and coordination.

USE IN PREGNANCY AND LACTATION: An increased risk of congenital malformations associated with the use of minor tranquilizers (meprobamate, chlordiazepoxide, and diazepam) during the first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of child-bearing potential may be pregnant at the time of institution of therapy should be considered. Patients should be advised that if they become pregnant during therapy or intend to become pregnant they should communicate with their physicians about the desirability of discontinuing the drug.

Meprobamate passes the placental barrier. It is present both in umbilical-cord blood at or near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breast-feeding patients, the drug's higher concentrations in breast milk as compared to maternal plasma levels should be considered.

Preparations containing aspirin should be kept out of the reach of children. Equagesic is not recommended for patients 12 years of age and under.

PRECAUTIONS: Should drowsiness, ataxia, or visual disturbance occur, the dose should be reduced. If symptoms continue, patients should not operate a motor vehicle or any dangerous machinery.

Suicidal attempts with meprobamate have resulted in coma, shock, vasomotor and respiratory collapse, and anuria. Very few suicidal attempts were fatal, although some patients ingested very large amounts of the drug (20 to 40 gm). These doses are much greater than recommended. The drug should be given cautiously, and in small amounts, to patients who have suicidal tendencies. In cases where excessive doses have been taken, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels. Hyperventilation has been reported occasionally. Any drug remaining in the stomach should be removed and symptomatic treatment given. Should respiration become very shallow and slow, CNS stimulants, e.g., caffeine, Metrazol, or amphetamine, may be cautiously administered. If severe hypotension develops, pressor amines should be used parenterally to restore blood pressure to normal levels.

ADVERSE REACTIONS: A small percentage of patients may experience nausea with or without vomiting and epigastric distress. Dizziness occurs rarely when meprobamate and ethoheptazine citrate with aspirin is administered in recommended dosage. The meprobamate may cause drowsiness but, as a rule, this disappears as therapy is continued. Should drowsiness persist and be associated with ataxia, this symptom can usually be controlled by decreasing the dose, but occasionally it may be desirable to administer central stimulants such as amphetamine or mephentermine sulfate concomitantly to control drowsiness.

A clearly related side effect to the administration of meprobamate is the rare occurrence of allergic or idiosyncratic reactions. This response develops, as a rule, in patients who have had only 1-4 doses of meprobamate and have not had a previous contact with the drug. Previous history of allergy may or may not be related to the incidence of reactions.

Mild reactions are charactenzed by an itchy urticarial or erythematous, maculopapular rash which may be generalized or confined to the groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema, and fever have also been reported.

More severe cases, observed only very rarely, may also have other allergic responses, including fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case), and hyperthermia. Treatment should be symptomatic such as administration of epinephrine, antihistamine, and possibly hydrocortisone. Meprobamate should be stopped, and reinstitution of therapy should not be attempted.

Rare cases have been reported where patients receiving meprobamate suffered from aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia. In nearly every instance reported, other toxic agents known to have caused these conditions have been associated with meprobamate. A few cases of leukopenia during continuous administration of meprobamate are reported, most of these returned to normal without discontinuation of the drug.

Impairment of accommodation and visual acuity has been reported rarely.

OVERDOSE: Two instances of accidental or intentional significant overdosage with ethoheptazine citrate combined with aspirin have been reported. These were accompanied by symptoms of CNS depression, including drowsiness and light-headedness, with uneventful recovery. However, on the basis of pharmacological data, it may be anticipated that CNS stimulation could occur. Other anticipated symptoms would include nausea and vomiting. Appropriate therapy of signs and symptoms as they appear is the only recommendation possible at this time. Overdosage with ethoheptazine combined with aspirin would probably produce the usual symptoms and signs of salicylate intoxication. Observation and treatment should include induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions.

DESCRIPTION: Each Equagesic tablet contains 150 mg meprobamate, 75 mg ethoheptazine citrate and 250 mg aspirin.

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*This drug has been evaluated as possibly effective for this indication.

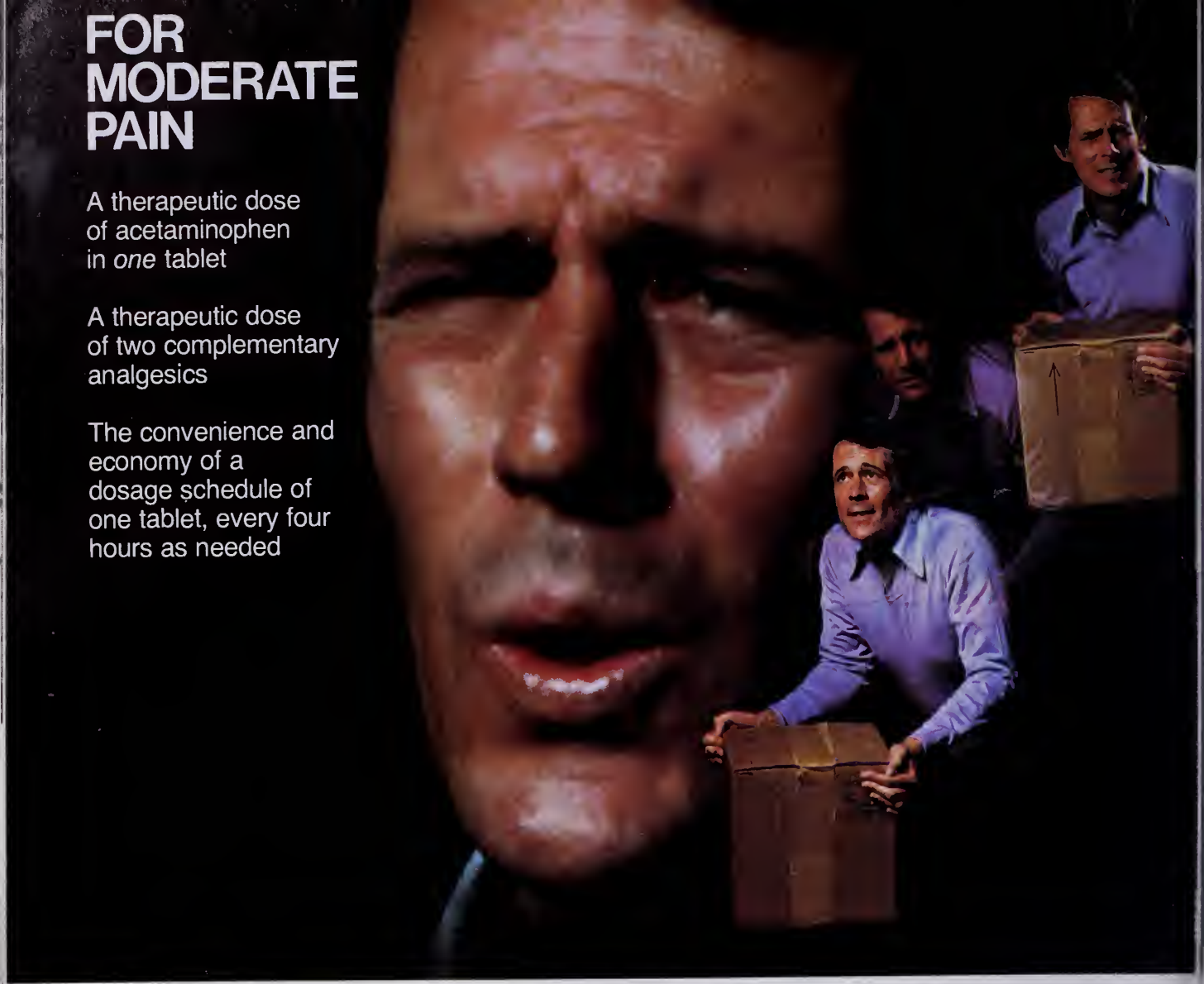
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FOR MODERATE PAIN

A therapeutic dose of acetaminophen in *one* tablet

A therapeutic dose of two complementary analgesics

The convenience and economy of a dosage schedule of one tablet, every four hours as needed



WHY NOT WYGESIC® C IV

(65 mg propoxyphene HCl and 650 mg acetaminophen) Wyeth

WYGESIC—Abbreviated Summary

INDICATION: For the relief of mild-to-moderate pain.

CONTRAINDICATION: Hypersensitivity to propoxyphene or to acetaminophen.

WARNINGS: CNS ADDITIVE EFFECTS AND OVERDOSAGE. Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, or other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. Toxic effects and fatalities have occurred following overdoses of propoxyphene alone or in combination with other CNS depressants. Most of these patients had histories of emotional disturbances or suicidal ideation or attempts, as well as misuse of tranquilizers, alcohol, or other CNS-active drugs. Caution should be exercised in prescribing large amounts of propoxyphene for such patients (see **Management of Overdosage**)

DRUG DEPENDENCE: Propoxyphene can produce drug dependence characterized by psychic dependence and less frequently, physical dependence and tolerance. It will only partially suppress the withdrawal syndrome in individuals physically dependent on morphine or other narcotics. The abuse liability of propoxyphene is qualitatively similar to codeine's although quantitatively less, and propoxyphene should be prescribed with the same degree of caution appropriate to the use of codeine.

USAGE IN AMBULATORY PATIENTS: Propoxyphene may impair the mental and/or physical abilities required for potentially hazardous tasks, e.g. driving a car or operating machinery. Patients should be cautioned accordingly.

USAGE IN PREGNANCY: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. INSTANCES OF WITHDRAWAL SYMPTOMS IN THE NEONATE HAVE BEEN REPORTED FOLLOWING USAGE DURING PREGNANCY. Therefore, propoxyphene should not be used in pregnant women unless, in the judgement of the physician, the potential benefits outweigh the possible hazards.

USAGE IN CHILDREN: Propoxyphene is not recommended for children because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric group.

PRECAUTIONS: Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine. The CNS depressant effect of propoxyphene may be additive with other CNS depressants, including alcohol.

ADVERSE REACTIONS: The most frequent adverse reactions are dizziness, sedation, nausea, and vomiting. These seem more prominent in ambulatory than in nonambulatory patients; some of these reactions may be alleviated if the patient lies down. Other adverse reactions include constipation, abdominal pain, skin rashes, light-headedness, headache, weakness, euphoria, dysphoria, and minor visual disturbances. The chronic ingestion of propoxyphene in doses over 800 mg per day has caused toxic psychoses and convulsions. Cases of liver dysfunction have been reported.

DRUG INTERACTIONS: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, and other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. (see **Warnings**) Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine.

MANAGEMENT OF OVERDOSAGE: SYMPTOMS. The manifestations of serious overdosage with propoxyphene are similar to those of narcotic overdosage and include respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, pupillary constriction, and circulatory collapse. In addition to these characteristics, which are reversed by narcotic antagonists such as naloxone, there may be other effects. Overdoses of propoxyphene can cause delay of cardiac conduction as well as focal or generalized convulsions, a prominent feature in most cases of severe poisoning. Cardiac arrhythmias and pulmonary edema have occasionally been reported, and apnea, cardiac arrest, and death have occurred.

Symptoms of massive overdosage with acetaminophen may include nausea, vomiting, anorexia, and abdominal pain, beginning shortly after ingestion and lasting for 12 to 24 hours. However, early recognition may be difficult since early symptoms may be mild and nonspecific. Evidence of liver damage is usually delayed. After the initial symptoms, the patient may feel less ill; however, laboratory determinations are likely to show a rapid rise in liver enzymes and bilirubin. In case of serious hepatotoxicity, jaundice, coagulation defects, hypoglycemia, encephalopathy, coma, and death may follow. Renal failure due to tubular necrosis, and myocardiopathy, have also been reported.

Ingestion of 10 grams or more of acetaminophen may produce hepatotoxicity. A 13-gram dose has reportedly been fatal.

TREATMENT: Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation. The narcotic antagonists, naloxone, nalorphine, and levallorphan, are specific antidotes against the respiratory depression produced by propoxyphene. An appropriate dose of one of these antagonists should be administered, preferably IV, simultaneously with efforts at respiratory resuscitation and the antagonist should be repeated as necessary until the patient's condition remains satisfactory. In addition to a narcotic antagonist, the patient may require careful titration with an anticonvulsant to control seizures. Analeptic drugs (e.g. caffeine or amphetamine) should not be used because of their tendency to precipitate convulsions.

Oxygen, IV fluids, vasopressors and other suppo tive measures should be used as indicated. Gastr lavage may be helpful. Activated charcoal can al sorb a significant amount of ingested propoxyphen Dialysis is of little value in poisoning by propox phene alone. Acetaminophen is rapidly absorbe and efforts to remove the drug from the body shou not be delayed. Copious gastric lavage and/or indu tion of emesis may be indicated. Activated charco is probably ineffective unless administered almo immediately after acetaminophen ingestion. Neith forced diuresis nor hemodialysis appears to be e fective in removing acetaminophen. Since acetam nophen in overdose may have an antidiuretic effe and may produce renal damage, administration fluids should be carefully monitored to avoid ove load. It has been reported that mercaptamine (cy teamine) or other thiol compounds may protect again liver damage if given soon after overdosage (8 hours). N-acetylcysteine is under investigation as less toxic alternative to mercaptamine, which m cause anorexia, nausea, vomiting, and drowsines Appropriate literature should be consulted for furth information. (JAMA 237:2406-2407, 1977)

Clinical and laboratory evidence of hepatotoxicity m be delayed up to one week. Acetaminophen plasm levels and half-life may be useful in assessing t likelihood of hepatotoxicity. Serial hepatic enzym determinations are also recommended.

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Hereditary Spherocytosis Unmasked by Infectious Mononucleosis With Autoimmune Hemolytic Anemia

Jayapandian Bhaskaran, M.D. and Donald R. Harkness, M.D.

Abstract: A young boy admitted to the hospital with high fever, lymphadenopathy, splenomegaly and hemolytic anemia was found to have infectious mononucleosis. The nongamma Coombs test was positive and his serum contained complement-fixing cold-reactive anti-i antibody. The patient was found to have previously undiagnosed hereditary spherocytosis. Family studies revealed that his mother and three of his siblings also had hereditary spherocytosis. Attention is called to the relatively high association between infectious mononucleosis and autoimmune hemolytic anemia in persons who have an underlying hereditary anemia. Possible reasons for this association are discussed. The criteria for establishing a diagnosis of hereditary spherocytosis are also discussed.

Excepting sickle cell disease and the thalassemias, spherocytosis is the most common hereditary hemolytic anemia. Its incidence is estimated to be approximately one in 5,000 in the United States.[1] Hereditary spherocytosis is an autosomal dominant disorder characterized by variable degrees of hemolytic anemia, splenomegaly, spherocytosis and increased osmotic fragility.

In the neonatal period hereditary spherocytosis may be associated with hyperbiliruabinemia which occasionally necessitates exchange transfusion. In some patients the disease may be moderately severe, causing chronic uncompensated hemolytic anemia, often worsening in association with intercurrent infections. Frequently, however, the disease is so mild that it is not recognized until adult life when the condition may be unmasked during an acute infection which either increases the rate of hemolysis or suppresses marrow erythroid production.

Recently we had the opportunity to see a young boy whose hereditary spherocytosis became apparent during an episode of autoimmune hemolytic anemia induced by infectious mononucleosis. The purpose of reporting this experience is to draw attention to the high incidence of underlying red cell abnormalities found in those rare patients with infectious mononucleosis who develop autoimmune hemolytic anemia and to summarize the probable reasons for this association.

Case History

The patient, an 11-year-old Caucasian boy, was admitted to the University of Miami Hospital on 3/19/76 with an eight day history of fever, malaise and tiredness. His mother gave the interesting history that the patient, one sister, and she had a viral illness five years earlier with decreases in their hemoglobin levels to 5-7 gm%. The mother had

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Supported by the Veterans Administration and a grant (RR 00261) from the General Clinical Research Centers of the Division of Research Resources, National Institutes of Health.

been seen by a hematologist at that time but no diagnosis was made. Red cell glycolytic enzyme activities had been measured and all were normal or elevated. Additional pertinent history indicated that the patient had been jaundiced at birth but exchange transfusion was not required.

On the day of admission the patient appeared extremely ill, was very pale and complained of weakness and dizziness. His temperature was 106°F and he had generalized lymphadenopathy, hepatomegaly and splenomegaly. The throat was unremarkable and there was no rash.

Initial laboratory data revealed: hemoglobin, 7.1 gm%; leukocyte count, 10,000/mm^3 with 70% lymphocytes, many of which were atypical; platelefs, 168,000/mm^3; reticulocytes, 11%; spherocytes were present on the peripheral blood smear (Fig. 1). The serum bilirubin was 2.2 mg% (2.0 mg% indirect); LDH, 537 units; cholesterol, 109 mg%; SGOT, 60 units; SGPT, normal. The chest x-ray revealed cardiomegaly but no hilar adenopathy. The mono spot test was positive.

The morning after admission the hemoglobin dropped to 6.4 gm% and blood was sent for typing and crossmatching. The blood bank reported that the direct and indirect Coombs tests were positive. Because the patient appeared so toxic he was begun on prednisone 10 mg QID. Within 48 hours his fever had subsided and he felt much better. However on 3/23 the hemoglobin was 5.5 gm%; reticulocytes, 22%; leukocyte count, 24,000/mm^3; and the platelet count was 91,000/mm^3. During the next several days the hemoglobin rose to 8 gm% and the white blood cell and platelet counts returned to normal.

Further serologic studies revealed that it was the nongamma Coombs which was positive. At 0°C the patient's serum reacted strongly (4+) with adult i cells (titer, 1:32) and from 1+ to 4+ with different cord blood samples. It also reacted weakly with adult group 0 cells. Heat eluates of the patient's cells reacted with 3 of 4 samples of cord cells and adult i cells but did not react with adult group 0 cells. The cold agglutinin titer was 1:64; the VDRL and ANA were negative. The heterophil titer drawn on 3/19 was 1:220 and on 3/22 was 1:320. The titer was not reduced by adsorption with guinea pig kidney antigen but was abolished by adsorption with beef red cell antigen.

Osmotic fragility studies on the patient revealed a nearly normal curve on freshly-drawn blood (Fig. 2). However, after sterile incubation at 37°C for 24 hours, the erythrocytes displayed increased fragility (Fig. 2). Autohemolysis studies revealed increased hemolysis which was partially corrected by the addition of either glucose or ATP. When repeated later, after disappearance of the immune hemolytic anemia, the hemolysis was increased but was more completely corrected by glucose. Studies performed on the patient's parents and six siblings revealed the presence of hereditary spherocytosis in the mother and in three siblings (Tables 1, 2 and 3). Further family studies were impossible since the mother had been adopted in infancy.

The patient was discharged from the hospital on 3/30/76. His hemoglobin rose to 11.0 gm%. In July 1976 he and two siblings underwent splenectomies. In June 1978 when they were all called in to [illegible] immunization with polyvalent pneumococcal polysaccharide, their hemoglobin values were normal.

Discussion

Hemolytic anemia is uncommon in infectious mononucleosis. Although Hoagland[2] reported its occurrence in about 3% of his cases, he gave no data to substantiate this; other large series report its incidence to be significantly less. The mechanism underlying the hemolysis associated with infectious mononucleosis has been suggested to be due to the temporary production of high thermal amplitude IgM cold agglutinins with anti-i

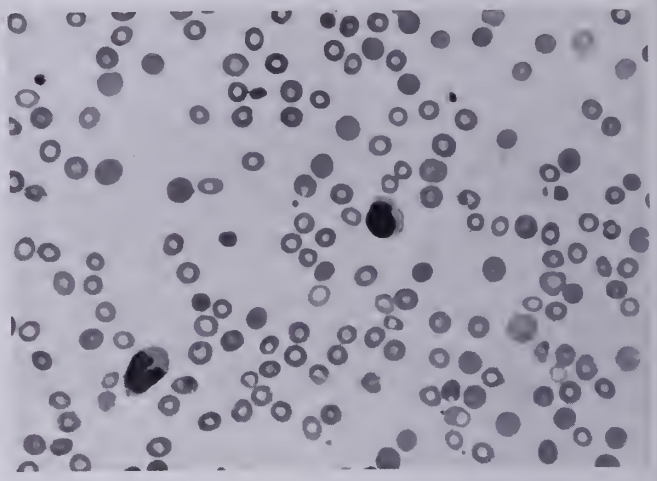


Fig. 1. — Patient's peripheral blood smear. Note the presence of microspherocytes and large stimulated lymphocytes or "virocytes" (x 500).

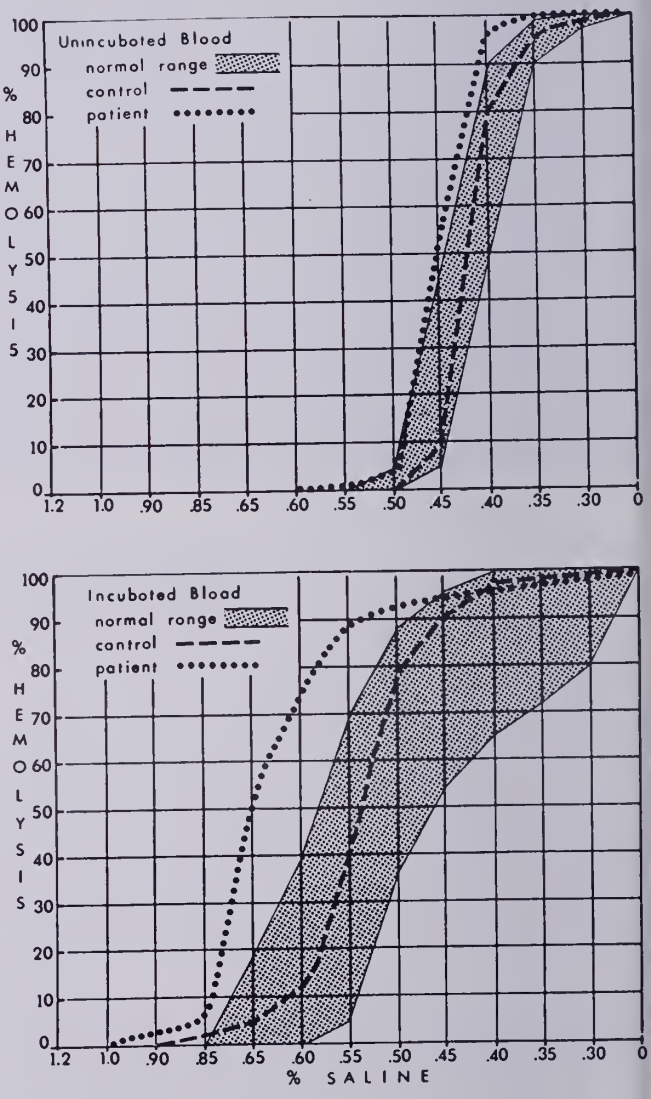


Fig. 2. — Osmotic fragility studies on unincubated and incubated (37°C for 24 hours) blood (x 500).

Table 1. — Miscellaneous Hematological Data on Patient and Members of Family.

	Hemoglobin	MCHC	Reticulocytes	Spherocytes	Serum Bilirubin Direct/Indirect
	gm%	%	%	0 - 4+	mg%
Patient*	9.0	35.3	11.8	4+	0.2/2.2
Mother	13.1	37.3	8.0	4+	—
Father	15.1	34.5	2.5	0	0.1/0.5
Sister 1	13.3	36.6	7.6	4+	0.1/0.9
Sister 2	12.4	35.5	16.4	4+	0.1/1.1
Brother 1	14.9	35.0	3.3	0	0.1/0.9
Brother 2	12.7	37.1	12.9	4+	0.2/2.0
Brother 3	13.0	34.2	3.8	0	0.1/0.4
Brother 4	12.1	34.0	1.5	0	0.1/0.1

*Values obtained when ill with infectious mononucleosis.

Table 2. — Osmotic Fragility Studies on Patient and Members of Family.

	Unincubated	Incubated
Patient	Increased	Increased
Mother	Increased	Increased
Father	Normal	Normal
Sister 1*	Normal	Increased
Sister 2	Increased	Increased
Brother 1	Normal	Normal
Brother 2	Increased	Increased
Brother 3	Normal	Normal
Brother 4	Normal	Normal

*Note normal value unless incubated.

specificity[3-7] analogous to the anti-I seen in mycoplasmal infections. The presence of a 7S IgG cold-reactive antibody directed against this same antigen has also been reported in the serum of a very high percentage of patients with infectious mononucleosis.[8] Others have questioned the role of these cold-reactive anti-i antibodies in the pathogenesis of the hemolytic anemia.[9] The puzzling aspect is that, although up to 90% of patients with infectious mononucleosis develop significant titers of anti-i antibody, the incidence of Coombs positivity (usually nongamma) is low and the incidence of hemolysis is even lower. In one patient the presence of an

Table 3. — Autohemolysis Studies on Patients and Family.

	No Addition	Glucose Added	ATP Added
	% Hemolysis		
Patient*	26.3	9.9	6.1
Patient**	28.6	2.6	4.8
Mother	24.4	1.9	1.9
Father	1.3	0.5	0.5
Sister 1	17.0	0.6	1.1
Sister 2	31.4	2.8	2.7
Brother 1	1.0	0.2	0.2
Brother 2	33.5	1.9	2.9
Brother 3	1.8	0.0	0.3
Brother 4	1.8	0.0	0.6
Normal range	0.2-4.0	0-0.6	0-0.8

*While Coombs test was positive.

**After Coombs test had become negative.

anti-N antibody was thought responsible for the hemolysis.[10] In other patients with demonstrated hemolysis no antibodies have been detected and it has been suggested that hypersplenism might account for the futher shortening of erythrocyte survival in at least some of these patients.

There is a significant incidence of underlying hereditary red cell abnormality among patients with infectious mononucleosis who develop severe hemolysis. This has been described in several cases of hereditary spherocytosis,[11-15] pyruvate kinase deficiency,[16] hereditary elliptocytosis,[17] thalassemia minor[4] and thalassemia major.[18] Several patients with previously undiagnosed hereditary spherocytosis were recognized only after developing unusually severe anemia with infectious mononucleosis, as was the case with our patient.

To understand the low incidence of hemolysis in infectious mononucleosis, despite the high frequency of anit-i, and the disproportionately high incidence of hereditary disorders of the erythrocyte among those patients who do hemolyze, we must examine the red cell i I antigen system. Normal "adult" red blood cells (erythrocytes in the circulation within months after birth) contain a high concentration of I surface antigen and a very low amount of i antigen. The reciprocal is true of the red cells of the fetus and for a few months after birth these cells possess high amounts of i antigen and low amounts of I antigen. The chemical relationship between I and i antigens is not known but the fact that they are related is suggested by their reciprocal relationship in

fetal and adult cells and the observation that rare individuals possess erythrocytes completely devoid of both I and i antigens.

In 1964 Giblett and Crookston[19] reported that in many hematologic diseases the red blood cells contain high reactivity to both anti-I and anti-i antibodies. They postulated that in these diseases the cells have a short transit time in the marrow and fail to "mature" with respect to losing their i antigen. The following year Hillman and Giblett[20] demonstrated conclusively that with "stress erythropoiesis" (shortened marrow transit time), such as is present when red blood cell production is inadequate to meet either normal or increased demand, there is premature delivery of developing cells into the circulation and that this shortening of normal marrow maturation is associated with increased i antigen on these cells.

These observations may help answer the dilemma posed earlier. In normal individuals who develop infectious mononucleosis the associated anti-i should cause little or no difficulty since it cannot react with the red cells. Hence the discrepancy between the presence of antibody but often-negative Coombs test. On the other hand, if there is an underlying hemolytic problem, the red cells would be expected to possess i antigen and therefore could be sensitized and destroyed prematurely. If this is the case, then this may be the explanation for the striking coincidence of hereditary erythrocyte abnormalities among the population of patients with infectious mononucleosis who develop a transient autoimmune hemolytic anemia. The obvious extension of this hypothesis is that when a patient with infectious mononucleosis presents with an immune hemolytic anemia, he should be investigated for an underlying disorder. Our contention is that the yield would be high. In our patient the presence of previously undiagnosed hereditary spherocytosis was detected because of the severity of the hemolysis accompanying a bout of infectious mononucleosis. Family studies lead to the detection of hereditary spherocytosis in three siblings and the mother.

It should be pointed out that, although we have attributed the severe hemolysis in our patient to immune hemolysis, implicating the anti-i on the surface of our patients red blood cells, we cannot be certain that immune mechanisms were involved at all. We do know that previously the patient and other family members with hereditary spherocytosis all had developed profound anemia in association with what was probably a viral illness. Since the erythrocytes in hereditary spherocytosis are sequestered and destroyed prematurely within the spleen, it should not be too surprising if hemolysis were more severe when the spleen is enlarged transiently in response to an illness.

A few brief comments should be made about the diagnosis of hereditary spherocytosis. Typically in addition to mild anemia, reticulocytosis, indirect hyperbilirubinemia and splenomegaly, spherocytes are prominent on the peripheral blood smear. Often the mean corpuscular hemoglobin concentration is above normal. Autohemolysis is increased and is corrected significantly by either glucose or ATP. Osmotic fragility is usually increased without incubation. If not, it must be abnormal after sterile incubation for 24 hours at 37°C; otherwise one is on tenuous grounds making a diagnosis of hereditary spherocytosis. All these points are illustrated in the laboratory data obtained during the evaluation of this family. It is important to diagnose hereditary spherocytosis correctly since splenectomy is curative for this disease whereas removal of the spleen may have little or no effect upon the hemolysis seen in association with many other forms of hereditary hemolytic anemia.

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Stress Management of Chronic Pain

Cynthia D. Belar, Ph.D.

The term "chronic pain patients" customarily refers to those patients who have experienced benign vs. malignant pain for six months or more regardless of cause. A major clinical and social problem, chronic pain is estimated to cost the nation over $10 billion per year in medical bills, lost wages, workers compensation and analgesics.[1] In terms of human suffering the cost is less measurable, but as significant. Chronic pain patients report feelings of frustration, helplessness and hopelessness. With increased time in pain, patients become progressively more depressed. Possible outcomes include suicide, medication abuse, loss of savings on bogus cures, and repetitive doctor shopping. The outcome for the physician is frequently frustration, anger, avoidance and then referral. According to research,[2,3] the average chronic pain patient has been in pain 7 years, has had 3-5 major surgical procedures, has spent $50-100,000 on medical bills, has a 50% chance of having acquired a drug habit, is most likely unemployed, and has disrupted interpersonal and recreational activities.

Clinicians and researchers in this area stress the importance of understanding psychological/behavioral components in the treatment of chronic pain patients. As Fordyce[4] notes, knowledge of pain is dependent upon patient behavior, either verbal or nonverbal. These pain behaviors are influenced by the same factors that influence all behaviors (i.e., learning principles), even if the initial cause of the pain is not learned. In fact, the dimension of chronicity ensures even more learning opportunities. Although the term "psychogenic pain patients" refers to those in whom there is no evidence of a noxious, organic stimulus, such dualistic thinking is over-simplistic and unrealistic since there are psychological/behavioral components in all chronic pain patients. The most fruitful approach is to utilize both psychological and physical models, one of which may be more helpful than the other, and to pursue indicated treatments in parallel.[5]

Assessment of Psychological Variables

Assessment of psychological variables and behavioral contingencies is required to design treatment programs which build in health vs. just remove disease. (Negative outcomes are possible as patients frequently experience difficulty coping with the major changes in life style associated with the disappearance of pain.) Evaluation should include exploration of three areas:

1) direct rewards for pain;
2) rewards via avoidance;
3) rewards for the absence of pain.

The special attention, sympathy and nurturance that patients receive for pain can directly reinforce it. This includes medical attention, which is usually contingent upon complaints of pain and which is needed as proof of illness to family and friends. One hypothesis is that early unmet dependency needs makes one more susceptible to a chronic sick role in later life. Research does illustrate that chronic pain patients tend to be later-born with many siblings who begin work at a young age ($\bar{x}$ = 16 yrs.) and who marry early, assuming family responsibilities while quite young.[3]

The manner in which medications are utilized can also reinforce pain, especially when prescribed on a **prn** basis. To obtain medication the patient must demonstrate need (pain behavior), and when taken **prn,** the experience of pain must increase before medication is warranted. These contingencies plus the direct medication effects of relief and sense of well-being can result in powerful reinforcement for the experience of pain. So it is with the programming of rest; activity to the point of maximum pain tolerance results in the relief of rest becoming contingent upon the experience of pain. Finally, compensation monies are direct reinforcers of pain behavior.

Pain can also be reinforced via its serving a protective function (e.g. avoidance of aversive or conflict-laden situations such as sex or familial responsibility). For others, pain is an organizing feature for their thoughts/lives, without which they might appear more seriously psychologically disturbed.

For many pain patients there are insufficient rewards for not being in pain. Employers often hesitate to rehire chronic pain patients on the advice of insurance companies, and at home, families tend to overprotect the sick, actually preventing and punishing self-care activities at times. Finally, the influence of anxiety and

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depression is substantial. With the original injury comes not just pain but also fears of disability, decreased sexual activity, and financial and family concerns to name only a few. Surgery might relieve the pressure on the nerve, but other problems can remain which cause tension, muscle spasms, pressure, and an increase in pain which produces more anxiety and tension.

A careful assessment of psychological variables is essential and can be accomplished by one who is professionally clinically trained. Clinical psychologists have found psychological tests to be helpful, especially in determining when medical treatments used alone are likely to be insufficient. For example, scores on the Minnesota Multiphasic Personality Inventory have been used to predict surgical outcome[6,7] as well as to indicate when antidepressant medication would be most helpful.[5] Identification of stressors for an individual patient is especially important, but is frequently difficult since many patients deny psychological concerns. "Psychological insight" can be facilitated through the recording of pain levels and details of situations of occurrence (pain diaries).

Stress Management Programs

The focus of stress management programs for chronic pain is to correct maladaptive behavior, whether it be emotional, cognitive, physiological or overt behavior, and to transfer these newly learned patterns to real life situations. Contrary to more traditional models in which the patient is a passive recipient of treatment, the patient assumes the major responsibility for sustaining or regaining health. The reduction of pain is a goal, but if not possible, the goal is for the individual to accept pain and to live as fully as possible.

Treatment regimens must be individually tailored, as in any psychotherapeutic approach. One common element to all stress management programs is the education component essential to all phases of treatment. The patient needs a conceptual framework for understanding his or her own response to stressful events (e.g., "When I'm in pain, I tense up and then my muscles go into spasms resulting in more pain."). Another component is learning to control stressors, either by avoidance, or where that would be either impossible or maladaptive, by learning strategies to cope. A variety of techniques have been found clinically useful in coping with chronic pain, although the research support for increased pain tolerance is mostly from experimentally induced pain studies. Such techniques include (1) collecting realistic information about the stressor, (2) reappraising its threat value, (3) using distractors to divert attention, and (4) acting on the environment in such a way as to reduce inputs to the pain (e.g., learning to deal with interpersonal conflicts so that avoidance via pain is not reinforced).

A final component in most stress management programs involves learning the relaxation response to counteract the physiological effects of the stress reaction and to develop a sense of somatic control. Progressive muscle relaxation exercises, autogenic training, and various forms of biofeedback have all been utilized. The sense of control gained from such relaxation skills may play a crucial role in the experience of pain. For example, it is known that experimental subjects will show less physiological arousal to painful stimuli when they believe they are in control of the aversive stimuli, even if in reality they are not in control.[8]

In summary, stress management programs involve (1) education, (2) use of techniques to control the inputs of stressors and variables which exacerbate pain, and (3) learning of skills to deal with the outputs of stress. Treatment design requires not only an understanding of the psychological make-up of the individual, but an understanding of the home environment as well. In fact, it is predicted that with less comprehensive treatment programs (e.g., those involving a two week massive effort to change a life style of chronic pain without attention to the psychological variables involved), there will be higher rates of relapse and post-treatment depression.

Case Illustration

The following case histories underscore the heterogeneity of chronic pain patients. Each patient was seen on physician referral at the Pain and Stress Management Laboratory, Department of Clinical Psychology, J. Hillis Miller Health Center. Throughout treatment each patient maintained a daily record of hourly pain ratings, medication usage, and associated activities. Jacobson[9] progressive muscle relaxation exercises were practiced twice daily; electromyographic (EMG) biofeedback and stress management psychotherapy sessions were held twice weekly. After voluntary control of specified muscles was learned, patients were gradually weaned from the electronic feedback and generalization of learned coping strategies was begun.

Case 1: Patient A was a 23 year old single female with a 10 year history of intermittent migraine headaches and almost continous tension headaches. Psychological evaluation revealed symptoms of marked depression, crying spells, sleep disturbance, mood swings, feelings of depersonalization, and difficulties in heterosexual relationships. Individual psychotherapy was begun immediately. The baseline period of Figure 1 reflects her headache activity during the first two weeks. Biofeedback was not begun until approximately four months later by which time her depression was significantly improved. There was, however, no reported change in headache activity. Over an 11 week period she received 17 treatment sessions with frontalis EMG feedback; she identified activities/situations such as group participation as associated with increased headaches. Individual insight-oriented psychotherapy ran concomitantly with this program. She was discharged from both approximately eight months after initial contact

and at six month follow-up remained free of tension headaches; she had had only three migraines, all of which were associated with an unusual life stress.

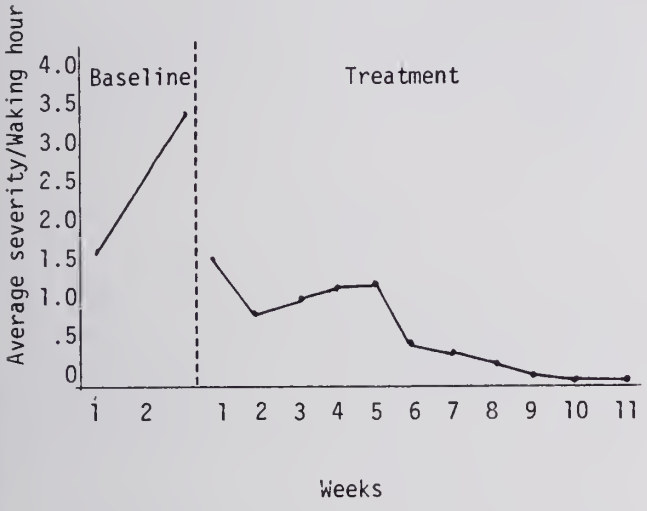


Fig. 1. — (Patient A) Average severity of headaches per waking hours (rated 0-5) across weeks of pretreatment baseline and EMG biofeedback treatment (4 months later).

Case 2: Patient B was a 47 year old divorced female who presented with severe neck and shoulder pain. The referring neurologist reported degenerative changes of the thoracic spine, and clinical evidence of bilateral cervical and trapezius muscle tension. She had been unable to work for 7 months, was generally inactive and appeared clinically depressed. Evaluation revealed that she had been psychologically floundering since her divorce eight years before, and it is hypothesized that her development of or inability to cope with pain at this time was in part an attempt to get help in reorganizing her life. Patient B received 17 treatment sessions with EMG biofeedback. Sessions also included supportive as well as stress management psychotherapy. Patient B did not report any significant decrease in pain throughout treatment although EMG data do reveal marked improvements in ability to relax cervical and trapezius muscles. What is significant is her reported feeling of control and her belief that she is coping more effectively, which is substantiated by her behavior. She began driving again; she began to work toward her high school equivalency diploma while holding a part-time job; and she resumed activities such as dancing and socializing.

Case 3: Patient C was a 71 year old married female with a 3 year history of marked paravertebral muscle spasm in the interscapular area. Three years prior to treatment she had sustained multiple compression fractures of the thoracic spine. In addition, she was diagnosed as having rheumatoid arthritis. Previous treatments had included novacaine injections, use of a brace, and use of a transcutaneous nerve stimulator, all without significant relief. At the time of evaluation she reported an inability to accomplish any activities while standing. Even with her inactivity, she experienced a minimum of one severe muscle spasm per day which sent her to bed for at least an hour. Psychological evaluation did not reveal significant emotional conflicts or secondary gain for her pain. After 10 EMG training sessions, in which feedback was provided from the site of muscle spasm, she reported being nearly free of backaches (Figure 2); resting levels of muscle tension also decreased. On one year follow-up she continues to do well. She travels, cooks, drives, and shops; if she notes the beginning signs of tension she practices her exercises. When backaches do occur they are less intense. (A more detailed description of this case is provided elsewhere.[10])

These cases demonstrate the heterogeneity of chronic pain patients both medically and psychologically. Patient A had rather severe psychological problems associated with her chronic pain problem which required individual psychotherapy. However, biofeedback appeared to be a necessary adjunct in order to learn the specific control required for her headache pain. Patient B had psychological problems but was not a good candidate for insight-oriented psychotherapy and was managed well within the stress management paradigm. For Patient C, no amount of general psychotherapy would have helped, she needed to learn a specific relaxation/coping technique. It is also noteworthy that report of pain is not the only relevant outcome. Patient B is doing well although still experiencing pain; if she had reported marked decreases in pain, but her depression had remained and her life had not become more rewarding for her, outcome would not be considered successful.

A cautionary note is indicated. Biofeedback and stress management techniques are not panaceas and cannot be used in a technical "package" manner without a comprehensive psychological understanding of the individual patient. Research is required to determine the effectiveness of various treatment components, for whom and under what conditions. Although there have been well-controlled studies concerning the use of biofeedback for tension headaches,[11] and long-term follow-up is available,[12] no such data currently exists for back pain patients. Thus the use of some of these techniques for the purpose of pain alleviation must still be considered experimental.

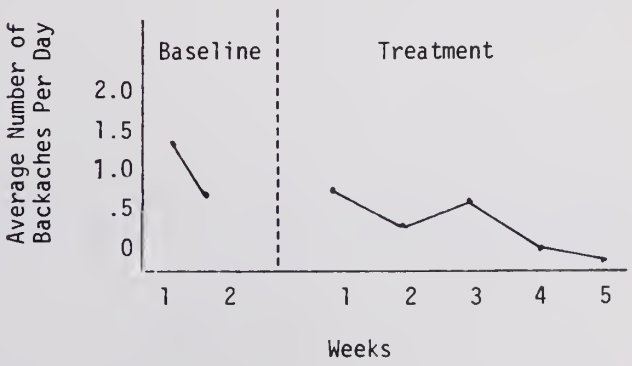


Fig. 2. — (Patient C) Average number of backaches per day across weeks of pretreatment baseline and EMG biofeedback.

Implications for the Practicing Physician

Since many chronic pain patients will balk at the idea of a psychological treatment program, reassurance that the physician does not consider their pain imaginary is usually required. Even pain which the physical language cannot explain is a real subjective experience. Bodily processes have been demonstrated to be subject to learning or conditioning, but it is helpful to underscore for the patient that this learning is not necessarily deliberate, but will occur automatically as behaviors are rewarded and punished over time. For patients managed in office practices, some generally accepted guidelines are as follows:

If analgesics are to be used, when possible prescribe medications on a fixed interval vs. **prn** schedule.

Encourage activity on a quota vs. tolerance system, with quotas initially set below tolerance level and gradually increased.

Sign disability papers for limited times, with the expectation communicated that the patient will seek other employment during that period.

For the patient who blandly denies problems associated with disability, interview family members in order to discover problem areas. Some confrontation with respect to the patient's lack of motivation may be indicated.

For the patient who must retire from the work force, facilitate this without shame or guilt while encouraging the development of rewarding activities/hobbies.

Be prepared to offer sexual counseling, perhaps encouraging a wider variety of sexual positions and activities.

In general, it is important to note that the nurturance so necessary to the case of acute pain patients may be destructive for chronic pain patients. One can have empathy and concern for the patient's plight, and respect for the integrity of the individual without assuming total responsibility for the patient's progress. In fact, to deprive the pain patient of that responsibility would perhaps be more insensitive and potentially more detrimental.

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No man is so foolish but he may sometimes give another good counsel, and no man so wise that he may not easily err if he takes no other counsel than his own. He that is taught only by himself has a fool for a teacher.

Ben Johnson

EDITORIAL COMMENT ..... Philip B. Phillips, M.D.

Dr. Belar is commended on her initiative in stressing the psychological aspect of chronic pain. This is a complaint with which each physician must deal. She has pointed out some of the various situations which seem to cause or aggravate the complaint of pain. When I see patients with the complaint of chronic pain, for which no organic basis can be determined, I am reminded of the saying of an elderly preacher who commented that, "there's many folks who is hurtin' in one place and gruntin' in another." This leads one to search for those family conflicts, frustrated aspirations, dependency needs, etc., which might exaggerate the patient's disability.

It was surprising to note her statement that "clinical psychologists have found psychological tests to be helpful, especially in determining when medical treatments used alone are likely to be insufficient." Few, if any, well trained psychiatrists would need psychological tests to determine whether medical treatments would be sufficient or not. Certainly the MMPI is not needed to indicate when antidepressant medication would be most helpful. A modern physician who fails to recognize depression is poorly trained for his profession. I would approve her comments concerning pain diaries and if the patient will cooperate, these can be useful.

Her reference to Dr. Edmond Jacobson was interesting in that I had the opportunity to know Dr. Jacobson and spend a week in his laboratory some years ago. Truly a brilliant and innovative psychiatrist and physiologist, his early work with biofeedback led to a useful treatment regimen for many patients. Dr. Belar failed to mention that many patients who have headaches or other bodily aches need to have these symptoms and if they are taken away, other symptoms may well develop. I could not support her recommendation of routine treatment with analgesics rather than their use prn. Weaning patients to a continuing decrease in medication is desirable if at all possible.

It is hoped that all physicians who have time to read this paper will find something helpful to them in the treatment of their patients with chronic pain.

RESPONSE TO EDITORIAL COMMENT ..... Cynthia D. Belar, Ph.D.

I would like to thank Dr. Phillips for his interest in my overview concerning chronic pain patients. However, he has apparently misunderstood the comments about the usefulness of psychological tests. Certainly any well trained physician or clinical psychologist can recognize depression without the use of psychological tests. However, not all chronic pain patients, most of whom are depressed, respond well to antidepressant medication (nor do all depressed patients). Experienced research clinicians suggest that various patterns of MMPI profiles may suggest differential effectiveness of various therapeutic regimens.[4] In addition there have been several studies indicating the usefulness of psychological tests in predicting surgical outcome. For example, in one,[6] the number of objective physical deficits did not discriminate between low back pain patients with excellent and those with poor symptomatic recovery one year post surgery. However, patients with T scores above 75 on MMPI scales Hs and Hy had less than a 16% chance of good recovery, while those with T scores less than 65 had a greater than 72% chance of good recovery. Several studies have replicated the usefulness of MMPI in clinical prediction. This is not to imply that psychological tests have "all the answers", but if tests can provide additional objective, quantifiable information which enables surgeons to estimate probability rates concerning recovery, then they are useful tools in clinical decision-making.

Routine treatment with analgesics was not recommended. It is well known that analgesics do not "cure" chronic pain, and in fact there are several documented cases where withdrawal from analgesics alone was an apparently effective treatment.[4] Rather the statement was "if analgesics are to be used, when possible prescribe medications on a fixed interval basis." Certainly this is a clinical decision to be made by the physician for an individual patient. Helpful in this decision making are the pain diaries.(including medication usage). It is often noted that self-medication bears no consistent relationship to pain level, and all too often patients may dangerously combine medications obtained from various physicians, or overmedicate. Most certainly, gradual weaning is desirable when possible.

Rather than having failed to mention that patients may "need" their pain, the fact that chronic pain may reflect significant psychological concerns was the major thesis of this paper. As indicated, a full assessment and understanding of the psychological make-up of the individual is required so that treatment programs can be designed which intervene in all areas necessary for healthier functioning. A misunderstanding of the function pain plays for an individual patient can only lead to poor treatment design, which of course is likely to be ineffective if not harmful.

Intraocular Lens Implantation

Michael R. Redmond, M.D.

Since the late 1960s, intraocular lenses (IOLs) have been used in the United States with increasing frequency as an alternative to eye glasses and conventional contact lenses in restoring useful vision to cataract patients. The IOL, usually made of plastic, is implanted permanently into the eye during cataract surgery, following removal of the clouded natural lens of the eye. Although approximately one fourth of the estimated 400,000 cataract operations performed each year in the U.S. now involve implantations of IOLs, questions continue to be raised about their use. A recent conference sponsored by the National Eye Institute provided a forum for discussion of the IOLs by experts in ophthalmology and vision research as well as representatives of consumer and professional groups.

Since implantation of the first intraocular lenses by Harold Ridley, M.D., F.R.C.S., in 1949, these devices have undergone a continuous evolution in design, weight, and manufacturing process. Also, surgical techniques for inserting IOLs, and for cataract extraction as well, have been considerably refined during this time. Currently used lens materials, with the exception of metal loops, are generally satisfactory.

Careful examination of the cataract patient before surgery is important, whether or not an intraocular lens implantation is planned. In addition, A-scan ultrasonography is of definite benefit in the preoperative examination. Although specular microscopy is also considered to be a valuable clinical and research tool, the panel said that it is not presently considered a routine part of the examination prior to primary lens insertion.

The panel recommended that, in general, intraocular lens implants be restricted to the elderly, that they be implanted in the eyes of slightly younger patients only when contact lenses or spectacles are not likely to provide adequate visual function, and that they initially be restricted to one eye unless the needs of the patient dictate otherwise. The panel also acknowledged other possible special indications for IOL implantation. Contraindications to implantation of intraocular lenses were also discussed.

The panel agreed that there are circumstances under which either intracapsular or extracapsular extraction would be equally suitable for cataract removal in conjunction with intraoculr lens implantation. Under certain circumstances, however, there may be a definite procedure of choice.

Excellent visual results have been reported for each of a variety of intraocular lens types, and some insight has been gained regarding possible advantages and risks associated with each. It was the consensus of the panel that the use of intraocular lenses is associated with a small but significant risk of additional complications beyond that of cataract surgery itself. Many of these may be transient or treatable medically and thus do not affect the visual result.

The panel discussed secondary implantation, bilateral implantation, and implantation in pediatric patients. The panel members emphasized that the patient should be made aware of the additional risks involved in secondary and bilateral implanation. They concluded that there is presently a limited role for secondary implantation of intraocular lenses, and they recommended a secondary implantation be limited to older patients who cannot wear contact lenses or spectacles, specifically to persons who are incapacitated by unilateral aphakia and who have a particular personal or occupational need for binocular vision. Because late complications have occurred in the occasional patient with the intraocular lens, great caution is indicated in considering bilateral implantation. The panel agreed that contact lenses should be considered before deciding on bilateral implantation and that bilateral implantation should not be used in younger patients except under unusual circumstances.

The panel also agreed that there were relatively few indications for lens implantations in children, although there is some feeling that an intraocular lens might be used in a child with unilateral congenital cataract.

The panel considered the many difficulties inherent to the use of spectacles for the correction of aphakia, although some recent improvements in spectacle lenses have made them somewhat more acceptable both cosmetically and functionally. Panel members acknowl-

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This is a summary of material presented at the Consensus Development Conference on Intraocular Lens Implantation sponsored by the National Eye Institute, assisted by the Office of Medical Applications of Research, National Institutes of Health, September 10-11, 1979.

edged both the advantages and disadvantages of conventional hard contact and soft contact lenses which are optically superior to spectacles but which may be difficult if not impossible for elderly persons and certain other individuals to handle. Although extended-wear lenses are a potentially significant advance in the treatment of aphakia, not everyone can be or should be fitted with them.

New surgical techniques to change the curvature of the cornea, for example, keratophakia or keratomilusis, are also undergoing rapid development.

The Food and Drug Administration's (FDA) approach to monitoring the testing of intraocular lenses was determined in part by a Congressional mandate which required regulation of the lenses and institution of an immediate study while not interfering with the availability of lenses. In the FDA study, all intraocular lenses are treated as investigational devices. First release of data was to be made at the American Academy of Ophthalmology meeting in November 1979.

Public comments were entertained by the panel. One ophthalmologist in the group and a representative from Ralph Nader's Health Research Group strongly criticized the current status of intraocular lens implantation. However, another ophthalmologist representing the Montana Foundation for Medical Care (a PSRO) described how widely-agreed-upon criteria for intraocular lens implantation were effectively used in his state as a basis for peer review of implant surgeons. Practice patterns were found to have changed to conform to the peer review standards and it was felt that improved medical care was delivered in Montana.

While the final long-term report is not yet out on intraocular lenses, this Conference's discussions show that there are definite advantages to be obtained by the patient who is carefully selected for intraocular lens implantation.

● Dr. Redmond, 8333 North Davis Highway, Pensacola 32504.

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Reaction to Presentations on Pediatric Drug Dosing

George A. Dell, M.D.

In the International Year of the Child, let us hope that all physicians and allied disciplines will share with you and with us in the private sector of pediatrics the concerns and needs for adequate guides in drug dosing. This has been eloquently described by the distinguished speakers. Your thoughts and concerns can be rapidly transferred with great benefit to the world of clinical pediatrics.

As we in private practice utilize these developing concepts and their applications, pharmacology and pharmacokinetics become distilled into "drugs and their actions — good and bad." This is the focal point of concern. I hope that the sands of time will not fall too slowly in the relentless pursuit of bringing for children those clarifications and new knowledge which will enable the pediatrician and his professional colleagues to reach useful and reliable conclusions to enhance the child's restoration to good health. This goal is sought through a more informed and accurate utilization of drugs.

As we try to absorb the catalytic presentations given today by these men of international reputation, let us remember the International Year of the Child. Let us join together in the rapid dissemination of newly-found, valid and clinically useful knowledge so that it may be applied to our carefully-sought therapeutic conclusions. Your work and pursuits can only be as useful and worthwhile as the practical application of these findings to fetus, child or young adult. Let us move forward, intent on formulating national and international guidelines in areas of mutual concern and quickly and convincingly aid those in policy-making positions to implement sensible and practical application of solid research findings into confirmed, clinical application.

Consider a problem that needs broad and accurate revision: quantifying the frequency and incidence of adverse drug effects and dosage on (1) the fetus, (2) the pregnant mother, (3) breast milk, (4) the child, and (5) the adolescent.

This involves changes in drug action in both normal and deranged cellular metabolism at all levels.

Presented at the International Year of the Child Mini Symposium on Pediatric Drug Dosing October 8, 1979 in Gainesville.

Dr. Dell is a practicing pediatrician at Gainesville and also Clinical Professor of Pediatrics at the University of Florida College of Medicine.

If we consult the Physicians' Desk Reference (PDR) or the American Medical Association book on drug evaluations, we see a varied assortment of actions and reactions and unfounded benefits, but also a grouping of clinically insignificant side effects and unnecessary caveats and precautions concerning adverse reactions to drugs. It is not very reassuring on the one hand for the clinician to be presented with a broadly-promoted, clinically-useful drug and on the other to be frustrated and discouraged out of its use by fears and concerns for the child or for medical, legal reasons.

There is a dilemma in the institution of a therapeutic regimen and we are showered by a cascade of adverse reactions, which may or may not be valid or clinically useful. For example, a drug may "cause depression, hypotension, anxiety, urticaria, pruritus, nausea, diarrhea," and on and on, with no mention made of incidence and no quantitation. I sometimes feel the message must be "use freely except in case of need."

Thus, the only practical solution would seem to be better or more accurate presentations of the real effectiveness and safety on drugs. These should be outlined as lists of adverse actions and reactions and this list should be in order of precise frequency and occurrence. This information should also be kept current.

Closely related to the problem just mentioned is the translation of harmful side effects and reactions which might concern the parent. This is, in so many words, "informed consent." We should be able to briefly outline the significant, potential problems that may arise with the use of a given drug.

It is difficult to formulate from sources currently available a useful and translatable packet of information for the lay parent. For example, one might say "This drug is excellent, but you should know that it may cause euphoria, hypoglycemia, glaucoma, and be carcinogenic, and again on and on." Not too helpful to the average patient.

The doctor is quickly frustrated in his attempt to document that the patient has consented because he or she is "informed."

Strong emphasis should be given to incorporating in appropriate publications significant actions and

reactions to drugs in lay terms. This should be specifically written for the patient and/or parent for their information and consent. For those concerned with the practical and clinical application of drug dosage and effectiveness, monitoring is needed to control exaggerated benefits that are sometimes present. Often the busy and less therapy-conscious physician is wooed by those anxious to promote new discoveries and products which may be prematurely released for general or limited usage.

Physicians are often ambivalent in seeing a reputable company with an impressive cadre of research and development teams also saddled with the very real responsibility of being economically successful and practical.

Once the leaders in the pharmaceutical industry implement the idea that physicians will use their products only on the basis of fact, then the public will reap the benefits of research and development offered by a solid force of dedicated professionals.

Let me next mention and applaud the emergence of a relatively new member of the medical team: the clinical pharmacists and pharmacologist. This is one of the most exciting and significant additions to improved hospital care.

For years we have bemoaned the useless waste of the prolonged training and education that goes into a pharmacy degree. Now there is a new group of bright, young professional pharmacists who think and act clinically and willingly participate in the active care of patients. Consultation and joint committee participation have come to be frequent. We see the welcome participation and amalgamation of medicine and pharmacy — for example, the resolution of a toxicology problem in a patient or the formation of a hyperalimentation program, or the implementation of a pediatric in-hospital dosing protocol.

We welcome this new and much needed member to the field of medicine.

Closely allied to the problem of finding out clinically useful drug actions and side effects is a public service which I hold close to my professional heart and value with great respect: The University of Florida College of Pharmacy "Drug Information and Pharmacy Resource Center." This center acts in cooperation with the Health Center, College of Medicine, and Library.

When a practicing physician is beset with a drug therapy or related problem, he is able to write or quickly telephone this center. He receives prompt and reliable attention. So you can see Private Practice and University working hand-in-hand to utilize a wealth of knowledge stored in our scientific resource centers. Interdisciplinary functions are at work solving practical problems confronting the physician, parent, and child in the area of drug dosing and related problems.

● Dr. Dell, 1010 Northwest 8th Avenue, Gainesville 32601.

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Estrogen Use and Postmenopausal Women
Condensation of NIH Conference Summary

Pierre J. Bouis Jr., M.D.

Abstract: The National Institute of Health has been coordinating a series of concensus development conference summaries concerning various health related topics. These conference summaries are sponsored by the National Institute on Aging and assisted by the Office for Medical Applications of Research of the National Institute of Health. These concensus development conferences bring together biomedical research scientists, practicing physicians, consumers and others in an effort to reach general agreement on the safety and efficacy of a medical technology. That technology may be a drug, device or medical or surgical procedure. The following article is a condensation of the concensus conference summary held on estrogen use. The summary was based on three physician papers prepared for the conference, the response of the panel and a general discussion by the audience. This was followed by an analysis of the conference by a pre-selected panel and other invited conference participants. This article reflects the conclusions reached by all those participating in the conference.

On September 13-14, 1979, the National Institutes of Health held a development conference on estrogen use and menopausal women. The following were addressed: (1) benefits and hazards of estrogen use, (2) treatment of postmenopausal symptoms and possible prevention of osteoporosis and (3) benefits and relative risks of various estrogen therapy.

It was accepted that estrogens were more effective than placebo in decreasing the frequency and/or severity of vasal motor symptoms, i.e. hot flashes and night sweats. There was general agreement that the decision to initiate estrogen therapy should depend on the severity of symptoms and the patient's perceived need for relief. If estrogen therapy is deemed necessary then the lowest effective dose should be utilized. However, unnecessary prolongation of therapy should be avoided.

It was generally accepted that estrogens are effective in overcoming vaginal atrophy and the associated symptoms of dryness, burning, itching and pain on sexual intercourse. Evidence now exists, however, that estrogen cream for vaginal application may be absorbed rapidly into the blood stream and the biological consequences of this absorption will require further study.

The use of estrogens to treat primary psychological dysfunction is not justified. Improvement in mental well-being in women taking estrogens is thought to be secondary to alleviation of their physical symptomatology.

Dr. Bouis is Assistant Professor, Department of Obstetrics and Gynecology, University of South Florida College of Medicine, Tampa, and Consulting Editor to *The Journal.*

Three randomized trial results presented at the conference indicated that exogeneous estrogens can retard bone loss if given around the time of the menopause. Other substances except for dietary calcium have not been shown to have such an effect. Although not proven, the retardation of bone loss may prevent the ultimate development of osteoporosis and resultant fractures. Case-control studies infer that the use of estrogens may decrease the risk of osteoporosis-related fractures. However, more data are needed before this can be firmly established. Certainly the identification of patients who are at increased risk of developing osteoporosis would be desirable because of the possibility of using estrogens as prophylaxis against bone fractures. The benefits of estrogen usage in patients who have developed osteoporosis and/or have had fractures will be investigated.

At the present time there is no convincing evidence that estrogens in customary doses increase the risk of thromboembolic phenomenon, stroke or heart disease in women who have undergone menopause. The hope that estrogen usage would protect against heart disease in aging women has not yet been established. Perhaps a more physiological mechanism for replacing estrogens is needed since oral replacement therapy results in the delivery of large concentrations to the liver and this may exert an effect on blood coagulation and lipoprotein metabolism.

The evidence for adverse effects associated with postmenopausal estrogen use was also reveiwed at the

conference. The incidence rate of endometrial cancer is approximately 1 per 1,000 postmenopausal women per year in the absence of exogenous estrogen use. It was pointed out that this rate increases several fold after two to four years use of 0.625 or 1.25 mg of conjugated estrogens per day. The risk of endometrial cancer increases with the duration of estrogen use and declines after its discontinuation. However, endometrial lesions of the lowest grade and earliest stage are associated with estrogen use. Mortality from endometrial carcinoma has not increased although the incidence of the disease has risen. This may certainly be attributable to early detection and a high cure rate.

Certain premalignant lesions of the endometrium have been associated with "unopposed estrogen." "Unopposed estrogens" may arise from endogenous sources (anovulatory conditions) or exogenous sources. The cost effectiveness of screening for premalignant lesions by sampling the endometrium in completely asymptomatic women currently receiving estrogens is still open to debate at present. It was agreed, however, that suction curettage is effective in evaluating the endometrium and that any patient who has bleeding must be investigated. Early endometrial cancer may not present with uterine bleeding and, therefore, some investigators feel that the endometrium should be sampled on a yearly basis in patients taking estrogen. Progestational agents used at the end of each estrogen treatment cycle have been shown to decrease the occurrence of premalignant endometrial lesions and, perhaps, may also reduce the risk of developing carcinoma of the endometrium. However, before combined therapy becomes an established practice the risk of using progestational agents must be evaluated.

Carcinoma of the breast in experimental animals has been shown to be linked to the use of estrogens. However, such a relationship in humans has not been established. The incidence of carcinoma of the breast has not changed in proportion to estrogen usage. The committee felt, however, that because of the poor prognosis and high incidence associated with breast carcinoma that any possible association with estrogen use is a concern.

Experimental studies indicate that estrogens may increase the risk of developing gallbladder disease by as much as 2.5 times that of the general population.

There was consensus agreement that patients should be given information regarding the "risks versus the benefits" of estrogen therapy. Patients should also be continually updated as new information becomes available.

The committee felt that the consensus summary was an excellent reflection of the current state of knowledge regarding estrogen usage. However, additional information is needed, specifically in the areas of alternatives to estrogen use, the optimal way to provide estrogen replacement and knowledge of the natural course of the menopause in the absence of hormonal therapy. The committee felt that each individual patient must face her decision to use estrogens on the relative values that she assigns to the relief of symptoms, to the expectations for optimizing health and well-being and to the various risks that may be sustained in the process.

● Dr. Bouis, Department of Obstetrics and Gynecology, University of South Florida College of Medicine, Tampa 33612.

Courage is the finest of human qualities because it guarantees all the others.

Winston Churchill

Exposure of Multiple Sclerosis Patients to Hyperbaric Oxygen at 1.5 — 2 ATA

A Preliminary Report

Richard A. Neubauer, M.D.

Editor's Note

In the tenure of every Editor, several articles will surface that engender enormous controversy. The following paper entitled *"Exposure of Multiple Sclerosis Patients to Hyperbaric Oxygen at 1.5-2 ATA: A Preliminary Report"* is one such manuscript.

This document has been reviewed by 12 different physicians both within and outside the State of Florida. The review covered a panorama of opinions including:

1) "It should be published as a preliminary report — even in the absence of a vigorous therapeutic and controlled trial of therapy."
2) "Represents but another form of therapy for a very remission-prone disease."
3) "Do not publish — very speculative — no scientific basis."
4) "Must be published: It may well turn out to be the most important paper ever published in our search for the understanding of multiple sclerosis. To have its wealth of clinical experience wasted, and its impressive results unknown for any length of time, would be comparable to the fate that befell Fleming's delivery of penicillin."
5) "Cures for multiple sclerosis — reported as 'possibilities' — or 'preliminary' are ubiquitous. They range from snake venom to lettuce diet. All show 'preliminary' improvement based, in large measure, on subjective patient reaction. Publication of this paper would lead to false hopes. It is based on no convincing evidence."
6) "Contents of this paper are of considerable scientific interest. This preliminary report is conservatively presented."
7) "Broad claims without statistical calculations."
8) "OK as an imformative provocative article. Double blind study going on in other centers will either substantiate or deny effects."
9) "No controls — no placebos. This is poorly explained — conclusions are unjustified."

Faced with this spectrum of reviews, the editors have grappled with this manuscript for months. In addition to the wide variety of consultant reviews, the editors themselves have been at odds with each other in regard to whether or not to publish this article.

On one hand, it might be considered that the publication of this article will prove to be a scientific landmark, one which will bring scientific lustre and prestige to *The Journal* for many years.

Conversely, the inclusion of this article in the pages of *The Journal* might be considered as an act of desecration — violating its scientific theme and staining forever the reputation of *The Journal*. Even more, it has been said that this article's publication will give the theme an aura of scientific respect that is not warranted. Furthermore, it could lead to the public's greater belief in, and utilization of, a modality of therapy that has no scientific basis. As such, the publication of this material would enhance the entrepreneurial aura of this proposed therapy, escalating even further the costs of the health care of patients with this disease.

The Editor has chosen to publish this article as one that should engender thought and discussion among the readers. He is confident that each physician reader himself can analyze the involved material and reach an appropriate conclusion.

The Editor

Abstract: Since Charot's original description of multiple sclerosis (MS) in the 1860's, physicians have been seeking its cause as well as an effective treatment without success.[1] This article presents data on a consecutive series of 250 MS patients who were exposed to hyperbaric oxygen (HBO). Most of these patients had a chronic progressive type of MS of long duration with no remissions for two or more years and would be unlikely to have a spontaneous remission. It appears that there is adequate observation with an apparently favorable outcome in a majority of patients for this preliminary report and for a recommendation of a more rigorous experimental trial of therapy.

Since Charot's original description of multiple sclerosis in the 1860's, physicians have been seeking its cause as well as an effective treatment without success.[1] The erratic course of exacerbations and remissions in MS makes evaluation of any form of treatment very difficult as has been demonstrated by ACTH studies.[2] This difficulty is compounded by the desperation of the patients and their families as well as by the emotional overlay of suggestibility, hysteria and conversion anxiety in many MS patients.[1,3,4]

With these facts clearly in mind, presented here are data on a consecutive series of 250 MS patients who were exposed to hyperbaric oxygen (HBO). The changes observed in these subjects do not necessarily represent improvements in the specific disease process of MS itself. Rather, they represent a combination of two factors. First is the spontaneously reported subjective experiences by the clinically evaluated subjects. Second is the careful objective observations of alteration in a variety of neurological functions which, although difficult to quantitate, tend to substantiate the patients' subjective impressions. Nearly all the hospital patients in this study were examined by several neurologists in conjunction with the attending internist, before, during and after HBO exposure. The author, an internist, was responsible for the evaluation of all out-patients.

Materials and Methods

The sex, age and duration of the disease is described in Table 1. Table 2 describes the patients dropped from the study because they did not complete 10 HBO treatments.

Extensive previous medical records were secured on all patients which substantiated a diagnosis of MS, using tests such as CSF globulin, immunologic, lymphocytes, electrophysiologic procedures and CT scan in combination with a detailed history and neurologic examination. Further, this diagnosis was confirmed locally, prior to treatment by a detailed history and neurologic examination along with review of complete prior medical records. In a few instances, where indicated, CT scans or other testing were done to complete diagnostic work-up. This confirmed diagnosis in each case. If there was the slightest question about the diagnosis the patient was not included in the series.

The results reported were obtained after the initial series of treatments. Most patients received 20 consecutive treatments at the rate of one to two a day, as described in Table 3. Some earlier patients received only 10 consecutive treatments. A few received up to 60 treatments. Although this MS series covers almost five years, few patients have been followed for more than two years because only six were treated in the first two years, representing too small a sample of five year duration to be statistically significant.

Table 1. — Treatment of Multiple Sclerosis With Monoplace Hyperbaric Oxygenation

		Number of Patients Treated	Place of Treatment	
			Hospital	Out-patients
Total Patients		262	74	188
Sex	Male	96	27	69
	Female	166	47	119
Age	< 30	34	8	26
	30-39	50	14	36
	40-49	83	21	62
	> 50	95	31	64
Duration of Disease	< 2 years	34	5	29
	3-4 years	17	2	15
	5-9 years	59	20	39
	>10 years	152	47	105

The Author

RICHARD A. NEUBAUER, M.D.

Dr. Neubauer is a practicing internist in Lauderdale-by-the-Sea.

Results

Figure 1 breaks down the degree of improvement as is suggested by Schumacher.[3] The cases included in dramatic improvement are those with complete or near total remission. The center bar, depicting minimal to moderate improvement, indicates patients whose changes ranged from minor to marked in up to two categories.

The center bar, depicting minimal to moderate improvement, is dropped from consideration so that a clear cut picture of "dramatic" improvement in 39% of the patients can be compared easily with the total lack of improvement in 9% of the cases. This comparison leaves no doubt as to improvement and is statistically significant.

Figure 2 depicts the degree of response in the various categories of multiple sclerosis listed below. All categories of MS responded to HBO. However, it should be noted that patients in the upper categories had more complete improvement while patients in the lower categories responded less in the area of improved mobility, but had meaningful responses in other areas.

Table 2. — Treatment of Multiple Sclerosis With Monoplace Hyperbaric Oxygenation

12 Patients Terminating Treatment Before 10 Treatments

Hospital Patients — #4	**Number of Patients**
Reasons	
Unrelated medical complications	1
Barotrauma	1
Bureaucratic red tape	1
Upset by hospital postponing treatment (ran out of O_2)	1

Outpatients — #8	**Number of Patients**
Reasons	
Claustrophobia	2
Barotrauma	1
Family problems	2
Profound fatigue	1
Psychiatric	2

These patients are not included in results graphs.

Table 3. — Treatment Plan Using Monoplace Hyperbaric Oxygen for Multiple Sclerosis

Initial Treatment with HBO

One or Two Treatments Daily According to the Following Schedule:

4 Treatments	1.5 ATA	60 minutes, minimum, with 90 minutes, if tolerated
16 Treatments	2 ATA	60 minutes, minimum, with 90 minutes, if tolerated

Consecutive treatments may be continued as long as the patient is improving, since absolutely no side effects other than occasional ear problems early in the series have been noted. When improvement levels off, continue as below.

Follow-up Treatment with HBO

In cases with favorable response, a minimum of:

1 Treatment monthly	2 ATA	60 minutes

Certain patients may need more frequent follow-up initially.

In cases of long term follow-up, intermittent treatments have been lengthened to as much as three months.

Supplementary Treatment

In cases of severe disability, it is advisable to use intensive physical therapy during the initial treatment, with continued physical therapy as needed. It is preferable for a neurotherapist to be used, if available.

All advanced cases should be concurrently followed by neurology and urology.

With the permission of the attending physician, the following drugs should be stopped at least two weeks prior to treatment: ACTH, steroids, antihistamines. Lioresal should be stopped or at least have the dosage markedly reduced.

If a Foley catheter has been in place for a prolonged period, besides urine culture, cystometric plus bladder sensation testing should be done. In some cases, bladder sensation has returned sufficiently to enable removal of the catheter and institution of bladder rehabilitation. If bladder symptoms are present, assuming infections have been brought under control, it is advisable to re-culture after the fourth HBO treatment, since again, many patients will achieve spontaneous improvement early in treatment.

Note

We feel that it is important to start patients at 1.5 ATA and gradually build them up to 2 ATA, as is in the protocol. In certain patients we find they improve at 1.5 ATA but when they reach 2 ATA the improvement stops. We drop these patients back to 1.75 ATA and the improvement continues.

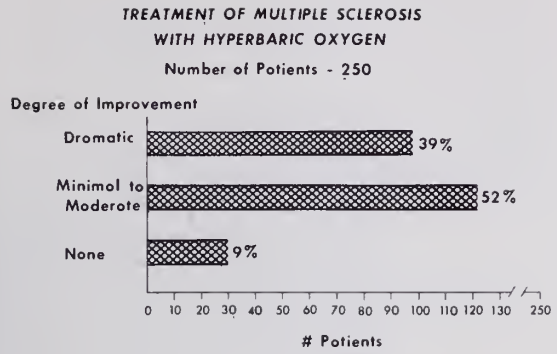


Fig. 1

Dramatic: Complete or near total remission.

Minimal to Moderate: From minor changes to marked changes in up to 2 categories.

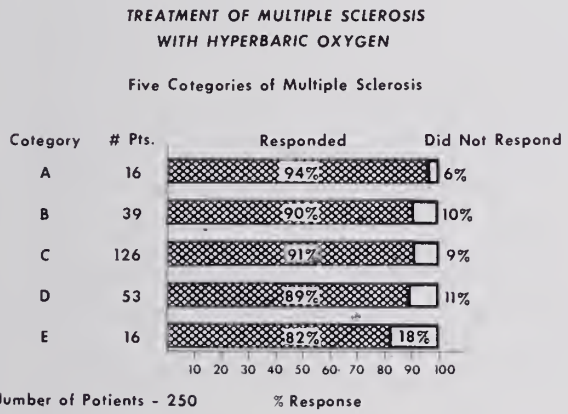


Fig. 2

Five Categories of Multiple Sclerosis

A. Signs and symptoms: Less than five years — minimal residual neurological damage, but has had remissions — no disabilities.

B. Residual symptoms more than five years: Minimum functional limitations — not disabled.

C. Signs and symptoms more than five years: Moderately disabled.

D. Disabled more than five years: Totally incapacitated.

E. Indeterminate: Does not qualify by definition of above. Long standing disease — little disability — not incapacitated, but recent progressive fulminating course.

These included such improvement as the ability to pivot after long-term inability to bear weight, reduced requirement for prescription drugs, less frequent need for hospital care, improved manual dexterity, vision, hearing, and mood, as well as less depressed. Such improvement was reported to be extremely satisfying to the patient as well as to the family. In addition, lessened medical care was cost effective from a monetary standpoint.

Figure 3 reflects movement of patients within the Kurtzke Disability Scale as described below the figure. Any movement within this scale tends to be a major one because the categories are rather broad.

Figure 4 depicts improvement in bladder and bowel control as related to the Kurtzke Scale described below the figure.[4] In most cases this improvement occurred without the use of drugs. However, when improvement was minimal or absent with HBO alone, drugs such as flavoxate hydrochloride (Uripas), hyoscyamine (Cystospaz), and bethanechol chloride (Urecholine) were added to the regime. This addition often resulted in improvement even though in many instances these drugs had been used previously by the patient with no benefit. In 38 of these patients this improvement was documented by changes in serial cystometrograms (see Figures 5 and 6). The serial cystometrograms were done before HBO was started and five to six days later.

The only complications in this series are described in Table 4.

Discussion

About five years ago, the author prescribed HBO for osteomyelitis in a patient with concurrent MS. It was noted that there was gross improvement in the MS symptoms during the HBO series. This improvement in MS disappeared soon after conclusion of the HBO treatments for the osteomyelitis and reappeared with reinstitution of HBO. Subsequently, patients with concurrent MS who were treated for other diseases were carefully observed, and similar improvement in MS symptoms was noted in most. Later reports on animal studies on experimental allergic encephalomyelitis (EAE), an animal model of MS,[6,7] indicated that HBO had a beneficial effect on this experimentally produced condition. The first American paper on the treatment of MS with HBO was published in 1978.[8] Our series of MS patients now numbers over 500.

Boschetty and Cernoch[9] had mentioned treatment of MS with HBO. Subsequent correspondence with Dr. Boschetty indicated that they had treated a series of MS patients who responded to HBO treatment at 2 atmospheres absolute (ATA) but they terminated the treatment when they noted that the effects did not last. This problem is resolved in our series by follow-up care.

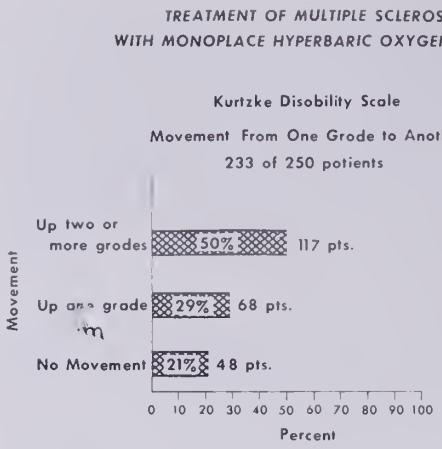


Fig. 3

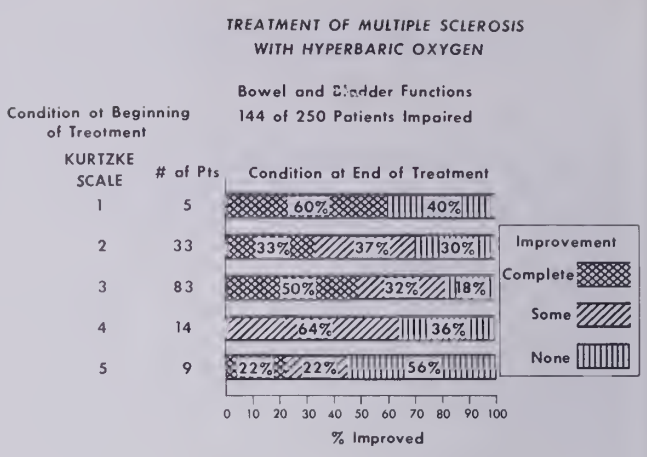


Fig. 4

Kurtzke Disability Scale in Multiple Sclerosis

0. Normal neurologic examination (all grade 0 in functional systems)

1. No disability and minimal signs such as Babinski sign or vibratory decrease (grade 1 in functional systems)

2. Minimal disability, for example, slight weakness or mild gait, sensory, visuomotor disturbance (1 or 2 functional systems, grade 2)

3. Moderate disability though fully ambulatory (for example, monoparesis, moderate afaxia, or combinations of lesser dysfunctions) (1 or 2 functional systems, grade 3, or several, grade 2)

4. Relatively severe disability though fully ambulatory and able to be self-sufficient and up and about for some twelve hours a day (1 functional system, grade 4, or several, grade 3 or less)

5. Disability severe enough to preclude ability to work a full day without special provisions. Maximal motor function: walking unaided no more than several blocks (1 functional system, grade 5 alone, or combination of lesser grades)

6. Assistance (cane, crutches, or braces) required for walking (combinations with more than 1 system, grade 5 alone)

7. Restricted to wheelchair but able to wheel self and enter and leave chair alone (combination with more than 1 system, grade 4 or worse; very rarely pyramidal system, grade 5 alone)

7A. Restricted to wheelchair without ability to enter and leave chair alone

8. Restricted to bed but with effective use of arms (combinations usually grade 4 or above in several functional systems)

9. Totally helpless bed patients (combinations usually grade 4 or above in most functional systems)

10. Death due to multiple sclerosis (In parentheses are listed usual equivalents for defects in the functional systems)

Kurtzke Scale

Bowel and Bladder

0 — Normal

1 — Mild hesitancy, urgency, retention

2 — Moderate hesitancy, urgency, retention, or rare urinary incontinence

3 — Frequent incontinence

4 — In need of almost constant catheterization

5 — Loss of bowel and bladder function

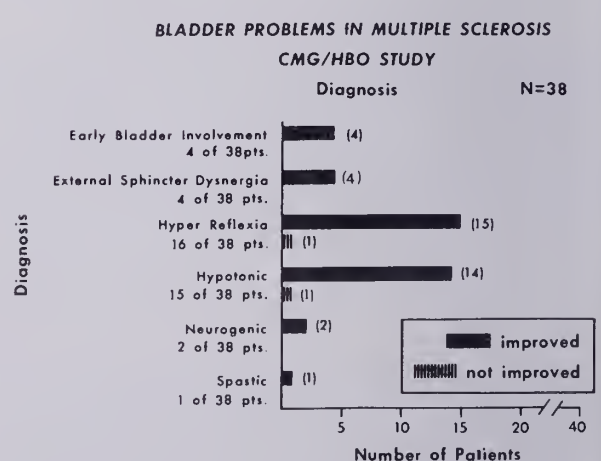


Fig. 5

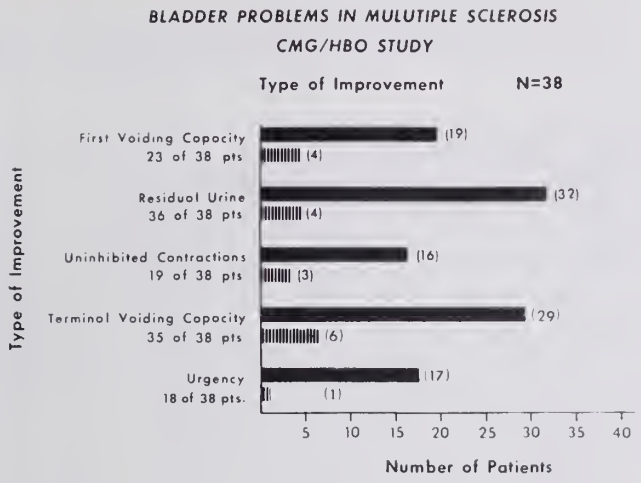


Fig. 6

A critical issue in the treatment of MS with HBO is the central dogma of *dose*. Dose is defined as a combination of pressure used and exposure time. We have never had an MS patient deteriorate during treatment due to too high a pressure. Certain baromedical physicians have treated series of MS patients at 2.5 ATA to 3 ATA with increased neurologic deficits in a significant percentage of them.

As is indicated in our treatment plan (Table 3), 2 ATA is the maximum pressure for the treatment of MS with HBO. Certain patients do better at 1.5 to 1.75 ATA rather than at 2 ATA. This is due to a variation in each patient's requirements and tolerance to pressurized oxygen.[10]

There is confusion over the terminology used for pressure in baromedicine and Table 5 compares 2 ATA with other commonly used measurements of pressure.

It is important to note that, as outlined in the treatment plan (Table 3), MS patients who improve after exposure to HBO tend to lose this improvement within three weeks to three months. At that time, a single HBO exposure will frequently peak most patients to their previous level of improvement.

The treatment of MS with HBO is non-invasive and essentially harmless. Response of MS patients after exposure to this modality was present in approximately the same percentage regardless of the duration of disease or degree of disability. Those in the early stages were more likely to attain complete remission coincidental with exposure to HBO. This is difficult to evaluate. Those in the late stages frequently had significant improvement but irreversible conditions such as long-standing immobility and disability would not respond. It is not possible at this time to select those patients who will not respond at all but with the high response rate attained, we feel there is justification for treating almost all MS patients. Patients with significant swallowing or breathing problems, or bedridden patients are no longer accepted for treatment.

As is described in Table 1, most of our patients were older ones with long-standing MS. Accordingly, a high percentage had the chronic progressive type of MS and had not had remissions for significantly more than two years in many cases. It is unlikely that such a patient would have a spontaneous remission, yet many did have partial remissions after HBO exposure.

It should be emphasized that the relationship of the subjective and objective improvement to the applied therapy remains an open question. It is difficult not to be impressed with some of the changes shortly following administration of HBO. It is equally difficult not to be impressed with the clinical course of those patients who received follow-up exposure to HBO. The response of this group regularly indicated that a transient beneficial effect seemed to occur. It appears that there is adequate observation with an apparently favorable outcome in a

Table 4. — Treatment of Multiple Sclerosis With Monoplace Hyperbaric Oxygenation

Complications	Total Patients	Hospital Patients	Out-patients
Barotrauma	23 of 262	6 of 74	17 of 188
Medication Prescribed			
Oxymetzaoline Hydrochloride	13	2	11
Pseudoephedrine Hydrochloride	3	1	2
Ventilation Tubes	7	3	4
Treatment Terminated Due To	2	0	2

Confinement Anxiety	Total Patients	Hospital Patients	Out-patients
	7 of 262	3 of 74	4 of 188
Tranquilizers	7	3	4
Treatment Terminated Due To	3	1	2

There were no other complications

Table 5. — Measurement of Pressure in Hyperbaric Oxygen

1 Atmosphere Absolute = 14.7 PSI = 760 mm Hg = Sea Level

2 Atmospheres Absolute = 29.4 PSI = 1520 mm Hg = 33 Feet Seawater

3 Atmospheres Absolute = 44.0 PSI = 2280 mm Hg = 66 Feet Seawater

majority of patients for this preliminary report and for a recommendation of a more rigorous experimental trial of therapy.

We acknowledge that this report does not meet the usual requirements for scientific proof as based on a controlled study. The difficulties of pursuing a controlled study in MS therapeutic trials have been emphasized in the past.[1,2,3] Those entailing a double-blind study in MS, notably in the application of a modality such as HBO, are obvious.

The author wishes to acknowledge the valuable assistance of Lorraine Steffen in the research and writing of this paper.

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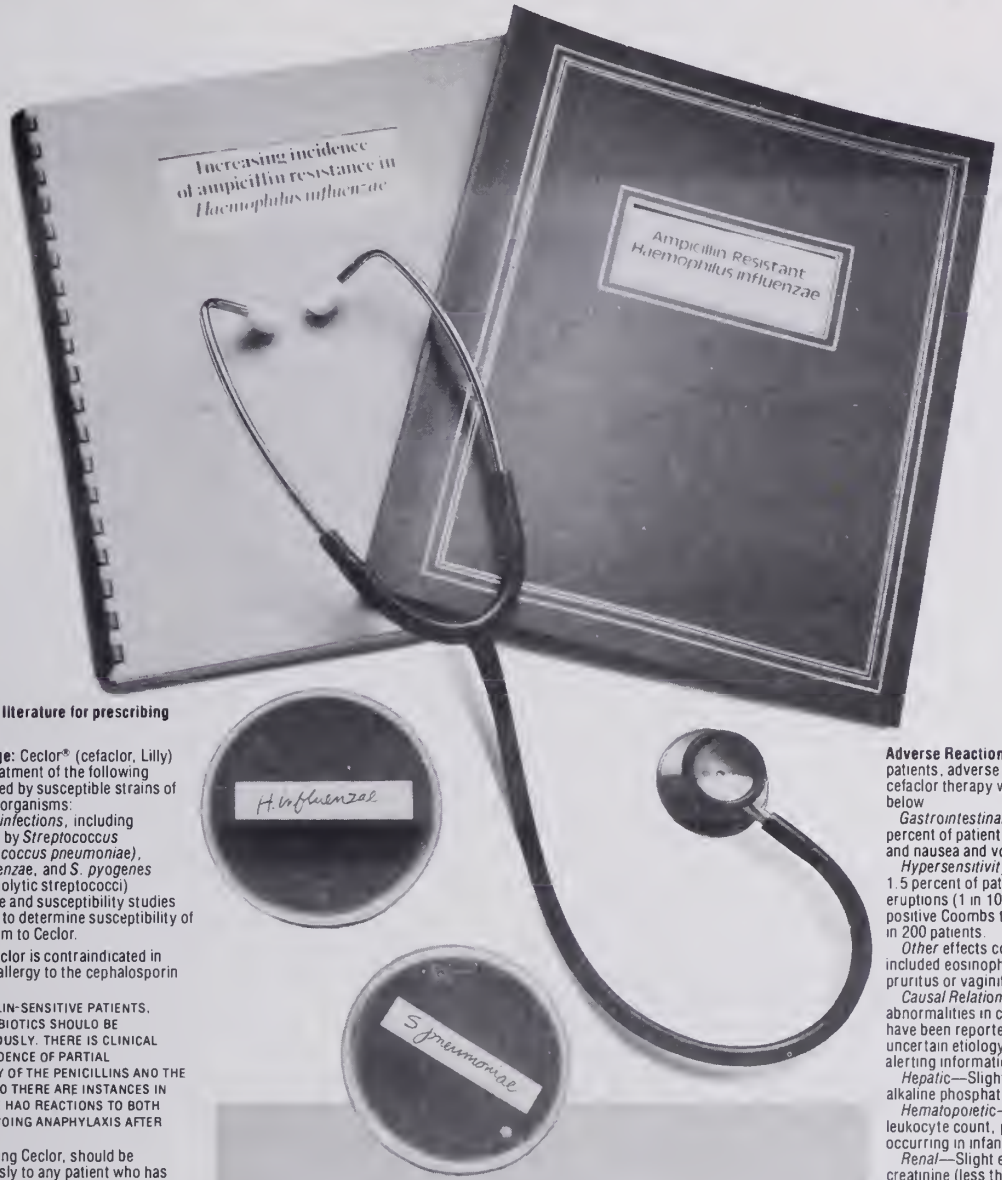
Portions of this article were presented at:

Neubauer, R. A.; Schnell, R.; Goldberg, G. S.: Treatment of Multiple Sclerosis with Monoplace Hyperbaric Oxygenation. Fourth Annual Conference on Clinical Application of Hyperbaric Oxygenation, Long Beach, California, June 7-9, 1979.

● Dr. Neubauer, Ocean HBO Center, 4001 Ocean Dr. #304, Lauderdale-by-the-Sea 33308.

It is actually a rare event when any of us ever has a totally original idea. We may put together old ideas into new combinations, but the elements which make up the new combinations are mostly acquired from other people. Without borrowed ideas there would be few inventions, movements or anything else that is classed as new.

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Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

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Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER PARENTERAL USE).

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefaclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

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Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

Usage in Pregnancy—Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy—Safety of this product for use in infants less than one month of age has not been established

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Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory tests results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

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* Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae* [8]

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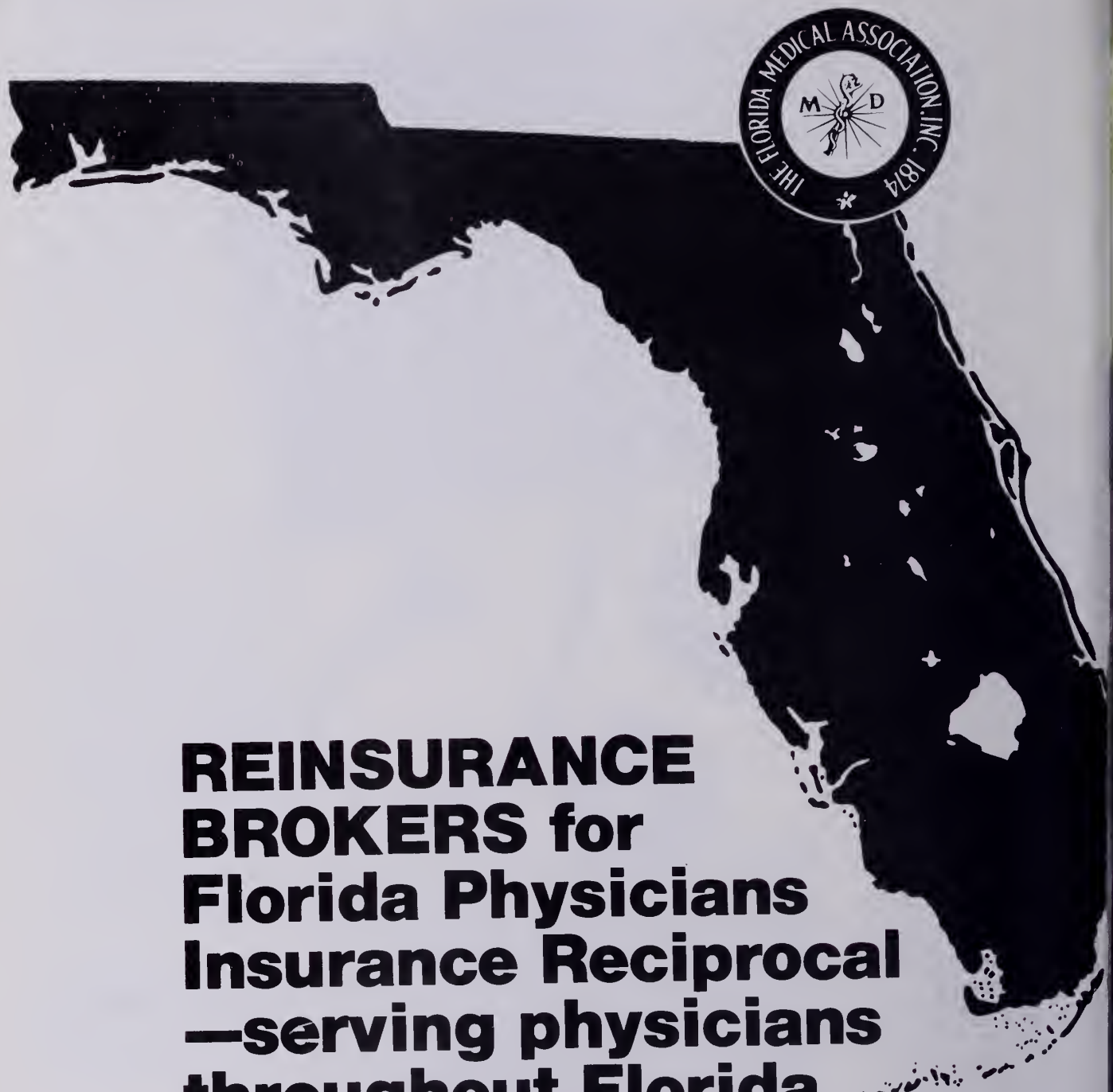
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DIRECTIONS FOR USE—ADULTS: Before breakfast and after the evening meal, one to two rounded teaspoonfuls of Perdiem™ granules should be placed in the mouth and swallowed with a full glass of warm or cold beverage. Perdiem™ granules should not be chewed. After Perdiem™ takes effect (usually after 24 hours, but possibly not before 36-48 hours), reduce the morning and evening doses to one rounded teaspoonful. Subsequent doses should be adjusted after adequate laxation is obtained.

IN OBSTINATE CASES: Perdiem™ may be taken more frequently up to two rounded teaspoonfuls every six hours.

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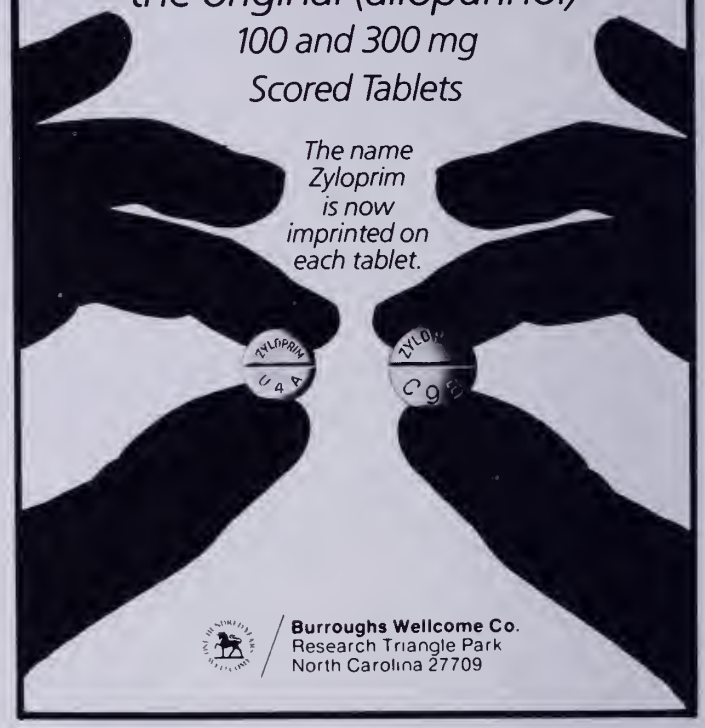
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SPECIAL ARTICLES

Summary of Physician Manpower Report for 1990

Kenneth E. Penrod, Ph.D.

The following is a brief summary of the 329-page Interim Report of the Graduate Medical Education National Advisory Committee.

In spite of a 30 percent increase in the aggregate supply of active physicians over the 1965-75 decade, there has been growing alarm over their specialty and geographic distribution with varying measures proposed for correction.

But the overriding question is: What is the proper mix of specialists and generalists and how many of each is needed for a given size population in a given area?

Out of this uncertainty grew a plan to establish an Advisory Council on Graduate Medical Education to the Secretary of the Department of Health, Education, and Welfare. On April 20, 1976 the Graduate Medical Education National Advisory Committee (GMENAC) was chartered to make recommendations to the Secretary on the present and future supply of, and requirements for, physicians, their specialty and geographic distribution, and methods to finance graduate medical education. The charter was subsequently renewed for a term extending through April, 1980.

The year 1990 was selected as the planning horizon. By then we will have replaced 30 percent of the current supply of physicians, and 40 percent of the physicians in 1990 will have been trained in 1979 or later.

The supply and distribution of specialty training slots available to medical school graduates will directly influence the future supply of specialists. Modification of the number and distribution of these positions may well be the primary influence on the future supply of physicians.

Dr. Penrod is Staff Director, Community Hospital Education Council, Tallahassee.

Present Physician Supply

According to the best data available — the AMA and AOA files — there were on December 31, 1976 378,572 M.D.'s and 13,982 D.O.'s professionally active in the United States. This total 392,554 is expected to increase to nearly 600,000 by 1990. This growth rate will outpace the U.S. population increase, so that the ratio will increase from 177 per 100,000 in 1975 to nearly 245 per 100,000 in 1990.

Primary Care Physicians

The Health Professions Educational Assistance Act of 1976 (P.L. 94-484) includes family medicine, general internal medicine and general pediatrics as primary care specialties.

Between 1963 and 1976 there was a negative growth in general and family practitioners (not differentiated by AMA) whereas general pediatricians and internists, increased in this same time period by more than 37,000. In spite of this increase the net effect has been a decline in the proportion of all active M.D.'s in primary care specialties from 42.1 percent to 39.0 percent in those 13 years.

Osteopathic Physicians

Between 1957 and 1976, two years for which reasonably comparable specialty data are available, the total number of active nonfederal D.O.'s increased from 9,620 to 13,980. At the same time, the number of D.O.'s in the primary care specialties declined numerically and proportionately (93 to 62 percent). Distribution-wise the largest number of D.O.'s are in Michigan and the smallest in Alaska.

International Comparisons

According to the *1977 World Health Statistics Annual*, the U.S. ranked with the top 15 percent of countries/areas in the ratio of physicians to population, standing 22nd out of 199 countries/areas as given in the report. The U.S. appears to have a low proportion of general practitioners among its physicians as compared to selected countries for which data were readily accessible.

Interns and Residents

In the 1976-77 academic year there was a total of 19,831 M.D.'s in the first year of residency training, representing a 79 percent growth since 1960. Of these 47.5 percent were in primary care, 28.5 percent in surgical specialties, 2 percent in other medical specialties, and 22 percent in other specialties.

The growth rate from 1960 has been far from evenly distributed. Primary care residencies have increased by nearly 6,000 (+174 percent) while all others have increased by only 2,762, or 36 percent. The apparent increases in first-year residents in primary care specialties may give an inflated indication of the eventual number of primary care specialists. Increasing numbers of first-year internists and pediatricians subsequently enter subspecialty or other nonprimary care training. For example, about 9 percent of those who entered first year residency training in internal medicine programs in 1973 were not enrolled in second year programs in 1974. About 8 percent of all the first-year residents in general pediatrics enter the pediatric subspecialties.

As of July, 1976, 47 percent of the 1975 third-year residents entered or were planning to enter a first-year fellowship, with an additional eight percent engaged in activities other than continuing training in general internal medicine and no more than 2,215 (38 percent) will enter the practice of general internal medicine.

Physicians continue to change their specialty after entering practice. In a recent longitudinal study containing samples of U.S. medical school graduates of 1960, 1964, 1968, it was found that 16 percent of those sampled changed their specialties between 1971 and 1976. Of those in this study who changed specialties, 78 percent did so after completing their training. In view of the possible shortage of primary care physicians, the study contains the disturbing finding that between 1971 and 1976, 127 of the 783 primary care physicians (16 percent) left primary care. Since only 68 of the physicians sampled reportedly shifted to primary care specialties during this period, a net loss of 59 physicians (7.5 percent) in the primary care sample occurred.

The surgical specialties have grown much more slowly than the primary care specialties, and the proportion of first-year residents in surgery has declined from 39 to 29 percent between 1960 and 1976.

Foreign Medical Graduates

The proportion and role of foreign medical graduates has increased significantly during the past decade. In 1963, there were 31,000 foreign medical graduates in the U.S. or 11 percent of the total physician population. In 1976, the figure had increased 20 percent of the total physician population. Furthermore, over 25 percent of all interns and residents in approved residency training programs are FMGs.

In 1976 there were 68,510 active foreign medical graduates in the U.S. Of this number, 35.9 percent were in primary care specialties, as compared to 39 percent of the U.S. graduates in primary care.

Geographic Distribution of Physicians

In general, the broader the specialty, the more uniform its geographical distribution. General and family practitioners have a more homogeneous distribution than any other group of specialists. Internists, pediatricians (and obstetricians) all have ratios below the national average in rural areas.

The disparity of the physician supply between urban and rural counties is further illustrated by the fact that in 1975, 87.1 percent of all nonfederal physicians were located in the nation's 300 major metropolitan counties where 75 percent of the population resides. Within these areas there are far more doctors in the suburbs and affluent urban areas that in the inner cities. On the other hand, there are 145 counties (most of them sparsely populated) which do not have active M.D.'s. Furthermore, nonmetropolitan areas have higher proportions of older physicians than the nation as a whole.

Projected Supply of Active Physicians

Projections indicate that the nation's supply of active physicians is expected to continue to grow rapidly, reaching nearly 600,000 by 1990. This increase represents an overall growth rate of 58 percent over the 15-year period from 1975 to 1990, somewhat more than the 50 percent rate achieved over the past 15-year period.

While growth is expected in all of the specialties and sub-specialties of medicine, it will not be evenly apportioned. Underscoring the current trend toward primary care, nearly half of the anticipated growth will probably occur in the four specialties labeled primary care (GP, FP, IM, PD).

Nonphysician Health Care Providers: Present Status: Impact on Physician Manpower Requirements: Future Alternatives

This chapter deals with the supply, training, and deployment of nonphysician health care providers in the PFIG specialties (pediatrics, family practice, internal medicine, general practice) and in obstetrics/gynecology. Research findings suggest that these providers, working under physician supervision, can, depending on the setting and patient mix, manage a substantial number of the tasks traditionally performed by the physician without compromising the quality of care — often with considerable cost savings.

If extenders are to have a significant impact on future physician manpower requirements, their numbers, training, utilization, level of responsibility and legal authority will need to be increased.

Who Should Pay for GME?

The question of who should pay for graduate medical education is both complex and controversial. Some argue that the costs of anything should be borne by those who benefit. In GME several distinct parties are directly involved — residents, teaching hospitals, medical schools and patients. If the relative value of the contributions and gains of each party could be determined, it might clarify the discussion of the proper allocation of GME costs. Although the problem is too complicated to address in this overview, one can begin to examine the contributions and gains to the primary beneficiary: The resident. It is argued that house officers should pay the cost of training including such expenses as teaching faculty, facilities, supplies, etc. They would, in turn, be paid for services to patients and teaching. Thus in theory, an equitable salary could be established at that level which reflects the value of services provided by the resident, less the cost of training.

Practically speaking, one cannot readily allocate GME costs precisely enough to arrive at a stipend figure in this manner. Because of variability among institutions and departments, overlap among activities of residents, varied budgeting and accounting practices in teaching hospitals and other methodological problems, it is unlikely that meaningful cost breakdowns for GME can be obtained without extensive further research. Thus, given available data on the service component of graduate medical education, GMENAC saw no evidence to recommend a shift from the current system of financing GME primarily from service revenues.

Impact of National Health Insurance on GME

If national health insurance were instituted, there could be major repercussions on the financing and nature of GME. The form which any NHI might take is uncertain, and there are not specific provisions for GME financing in any of the proposals under consideration.

GMENAC is concerned that developing national health insurance policies make appropriate provision for financing graduate medical education.

Implications for Florida

At the end of 1976 Florida was approximately 10% short of the national average of total active physicians. There was considerable variability among the specialties with the greatest surplus relative to the U.S. total in cardiologists (+59%) and the greatest shortage in psychiatrists (-33%) followed by internists, neurologists and pathologists in that order.

If the GMENAC forecast of 600,000 active physicians in the U.S. in 1990 is realized then we can expect the number in Florida to approximate 29,000 based on population proportion. Florida's population is projected to be 11.7 million in 1990; that of the U.S. 243.5 million.

Largely reflecting training opportunities available the number of internists in the U.S. is expected to increase disproportionately in the next decade. The net growth (new additions less deaths and retirements) is projected at 61,600, including the medical subspecialties.

Since Florida had a relative deficit of internists in 1976 our increase during the 1980's will need to be well over 3,000 to "catch up" to the U.S. average.

The second greatest increase will need to be in general/family practitioners to attain U.S. parity. Here the net increase will need to be over 2,000 with an added factor of greater than normal attrition associated with average age.

The third largest increase group will be pediatricians. The net increase for Florida is projected to be about 1,500 for a total nearly three times the present number in the state.

Other specialty increases can be expected to be more modest in total number but do imply a doubling of present numbers in some instances. Any specialty projection may, however, be altered by a number of factors including particularly changes in training opportunities.

The total net increase in active physicians in Florida between 1976 (14,183) and 1990 (28,719) does not appear to be unreasonable, or even unexpected, in the light of a recent growth rate approximating 1,000 per year.

● Dr. Penrod, 107 West Gaines Street, Tallahassee 32304.

Comments on The Ethics of Death

Ruth E. Coleman (Mrs. Frank)

Abstract: This article describes man's increasing lack of control of the way he dies and the problems he encounters as he approaches death. Fear, loneliness and concern are all a part of this scene. Are there ways we can assist ourselves and others in making the last stage of death one of dignity and peace? Some suggestions are given.

During the Middle Ages the dying person presided over his death and knew its protocol. Then the family began to take control. Today the initiative has passed to the doctor and hospital team. Death in the hospital is no longer an occasion over which the dying person presides amidst his relatives and friends. It is a technical affair which is arrived at by a series of little steps. The great dramatic act has been lost.

With an ever-increasing percentage of our society over 65, we must realize the problems of dying and discuss them openly. American society is ignorant of the process of death. Laws, legal and ethical, affect the patient and his family; the patient's emotional reactions and his fear of physical pain present another set of problems.

"Death is a relatively recent invention in biology," says Dr. Thomas Lewis. Until the development of sex, single-celled organisms lived by binary fission; there was no such thing as natural death. It was only the success of the sperm and egg that introduced us all to death as an imperative.

It was billions of years more before the concept of death was developed. The most essential characteristic of primitive man was the place he held in the clan and once he realized himself as a separate unit within that clan, he was on the path of discovering the inevitability of death. The growth of logical reasoning allowed him to draw from the happenings around him a general rule that "all men are mortal." Once these steps were taken, individual man knew through experience that he, too, had to die.

During the Middle Ages death was a ritual organized by the dying person himself, who presided over it and knew its protocol, but from the Middle Ages on, in the upper classes, there was a subtle modification of the familiar resignation toward the collective destiny of the species; individual traits of each life became more important.

Western man became concerned with the death of the other person during the 18th and 19th centuries. The initiative passed from the dying man himself to his family.

Today the family is as much an outsider as the dying person and the initiative has passed to the doctor and hospital team. They are the masters of death — of the moment as well as of the circumstances. Death in the hospital is no longer an occasion over which the dying person presides amidst his relatives and friends. Death is a technical phenomenon which is arrived at by a series of little steps. We do not know which is the real death, when consciousness is lost, or breathing stops, or when the machine is turned off. The great dramatic act of death of the past has been lost.

The facts that during the last century modern medicine has added 25 years to man's life span, that an increasing percentage of our population is over 65, that modern family living allows no place for the elderly, and the cost of hospitalization and dying is rising, have all added to the necessity of a more open discussion of the problems encountered by the dying.

The first problem is that American society as a whole is ignorant of the process of death. The average American experiences death in his family only once every 20 years.

Laws, legal and ethical, affect the patient and his family both emotionally and legally. Pinning down the moment of death and whether to prolong the life of a dying patient are examples of these. The use of positive or negative euthanasia brings legal, ethical and theological problems to all concerned. The patient's emotional reactions present problems. From talking with dying persons, Dr. Elizabeth Kubler-Ross has outlined

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This is a short version of a thesis Mrs. Coleman wrote entitled "An Approach to Death," to obtain her degree from the University of South Florida several years ago.

five stages a terminally ill person experiences in his anticipation of death:

The first stage is denial. (No, not me; it can't be true.) But sooner or later he will have to face the reality and he enters the second stage, profound anger, a "Why me?" attitude. Dr. Kubler-Ross suggests that we assist this angry patient rather than judge him, that we not take his anguish as a personal insult, and that we encourage him to express his feelings. The third stage is a period of bargaining. Often the patient tries to make a deal with God (or with the doctor) for more time or less suffering. In the fourth period he becomes deeply depressed and begins to lose interest in the outside world; he may not want to see his family; they may feel rejected, but his family must "let go", allow him to grieve, and disassociate himself from life. If allowed to pass through the first four stages, he should reach the fifth and last stage, acceptance. This is a courageous time when a person has accepted the reality of mortality. In a genuine stage of acceptance, a patient shows a feeling of equanimity and peace. There is a dignity about him.

Fears are problems. One of the sources of fear as man approaches his own death stems from the thought of physical pain and suffering. Sometimes this fear is justified, but more often it is not. Reassurance comes to the dying if it is clearly demonstrated that nurses and doctors have every intention of controlling discomfort.

Another fear is that of loneliness. "Our embarrassment at the individual face of death forces the seriously ill and dying person to live alone on the brink of an abyss with no one to understand him" is the observation of Dr. Herman Feifel, professor at USC.

Sometimes the patient is more concerned about his family than he is about himself. He is concerned with their readjusting to reality; he feels guilty about leaving them. The dying person needs to receive permission from every important person he will leave behind him. Then he can begin working on his next problem; letting go are at the heart of dignified and peaceful dying. This takes the assistance of understanding friends.

These are the problems we have to face. Some can be controlled, others not. What then is our own outlook for a "good death"?

To prepare to have a good death, whatever our definition of that might be, we must know that death is but an extension of our life style. We learn to die well by learning to live well. Conversely, Paul Tillich says, "If one is not able to die, is he really able to live?"

In history, in literature, in philosophy, the theme returns again and again: to learn to die well, we must learn to live; to learn to live well, we must learn to die. Each is part of the other.

● Mrs. Coleman, 4111 Carrollwood Village Drive, Tampa 33624.

We flatter ourselves by claiming to be rational and intellectual beings, but it would be a great mistake to suppose that men are always guided by reason. We are strange, inconsistent creatures, and act quite as often, perhaps oftener, from prejudice or passion. The result is that you are more likely to carry men with you by enlisting their feelings, than by convincing their reason.

John Lubbock

Florida Department of Health and Rehabilitative Services

David H. Pingree

Statement to the FMA Board of Governors, October 11, 1979, Colorado Springs, Colorado

It is truly a pleasure for me to be here this morning to meet with the Board of Governors of the Florida Medical Association. We in the Florida Department of Health and Rehabilitative Services (HRS) strongly desire to have a constructive working relationship with the medical community, and are greatly appreciative to the Florida Medical Association (FMA) for its many supportive and constructive efforts on behalf of the citizens of Florida and the clients of our Department. Particularly, I wish to thank the FMA for its efforts in locating qualified candidates for top-level medical positions within the Department including those of State Health Officer and Mental Health Program Office Staff Director.

Governor Graham and I are committed to the enhancement of the health role within the Department of HRS. We want to involve health providers, especially physicians, in the State's decision-making process relative to health and medical issues. The time has come for us to join hands and lock arms together on those issues on which we agree; we need coalition and cooperation, rather than confrontation.

As I review your legislative proposals for the 1980 session and compare them with proposals the Department is preparing for presentation to the Governor and the Legislature, I see many issues on which we agree — in fact, a majority of issues. In these cases, we should appear before the Legislature as a unity presenting a common front on behalf of the health needs of Florida's citizens. Where there is disagreement, we will continue to oppose one another; but for the sake of improved health in Florida, let's work as partners whenever that proves to be feasible.

In the past, many of you have felt that a separate Department of Health was needed to assure that health issues and needs received adequate attention in Florida. I do not believe that such is necessary. Health has a significant, if not preeminent, place within the Department of HRS. It is the sole priority of Health and Rehabilitative Services' programs which the Governor has chosen for emphasis this year. Furthermore, we have fought for and received millions of additional dollars in appropriations for children's medical services, emotionally disturbed children, school health services, Medicaid, and other health related programs.

Let me reiterate and emphasize that the Governor and I are committed to significant improvements in the general health of Florida's citizens. We are concerned that we are not among the nation's leaders in many of our programs and services. Our goal is to make Florida's programs models after which other states will want to pattern their programs. We want your help in this endeavor.

In my remarks this morning I would like to bring you up-to-date on a number of developments in which I think FMA members might have an interest.

Medicaid

We have recently appointed Bob Williams, a long-time top administrator in the Department of HRS, and a former hospital administrator at Shands, North Florida Evaluation and Treatment Center, and Florida State Hospital, as the Deputy Assistant Secretary for Medicaid. We are in the process of reorganizing the Medicaid program to make it more efficient and effective and more responsive to the needs of both clients and providers. Whatever assistance you can give Mr. Williams is welcomed. Where you are experiencing problems, contact him directly. Of course, I am available to you as well. We will see if we can take immediate corrective action. If not, we will tell you what we can do and when.

I know that one complaint of physicians has been that there has been no increase in physicians' fees since

Mr. Pingree is Secretary, Florida Department of Health and Rehabilitative Services, Tallahassee.

1972. This problem is currently being addressed and changes will be implemented on October 1, 1980. The Governor and the Legislature did take note of this problem and provided funds for this purpose, but not until the last three quarters of the biennium. In addition, it is the Department's intent and that of the Executive Office of the Governor, to increase physicians' fees to the 50th percentile over the next few years, which would be a significant increase over the current fee schedule. A continuing review is also promised.

A recent development which is especially noteworthy is that HEW — in September — certified our Medicaid Management Information System. Many of you experienced problems with the System Development Corporation (SDC) and late payments during 1978. According to our figures, which I have recently reviewed, these problems have been corrected and you should be receiving accurate payments in timely fashion. I again urge you — if you are experiencing any continuing problems — to contact either Bob Williams or me.

After years of talking and little action, we have recently appointed a restructured Medicaid Advisory Council which will be holding its first meeting on October 16, 1979. We anticipate that this advisory body — comprised of consumers and providers — will assist us greatly in the early identification of problems with our program so that we can take corrective action before being faced with crises. If you are experiencing problems, you may wish to contact your representatives on the council so that they can raise these issues with Bob Williams in that forum.

Another significant event will occur later today when you consider the Peer Review contract, which the Department of HRS is proposing to the Florida Medical Foundation. This is a significant step toward greater cooperation and improved delivery of quality services to the citizens of Florida.

Statewide Health Coordinating Council

I recognize that many of you have had problems in the past with the statewide health planning process and portions of the State Health Plan. We feel that the hearing process of the past two years has done much to surface concerns of medical providers and consumers. In fact, the final revision of the 1979 State Health Plan bears the direct imprint of persons such as yourselves who commented in public meetings. Of additional interest to you will be the changes introduced in the federal health planning legislation this year. This law, recently signed by President Carter, authorizes greater direction and control of state health planning by the Governor and the Department, which should lead to the State Health Plan being a more accurate representation of the State's health policy as enunciated by the Governor, the Legislature, and the Department as well as members of the Statewide Health Coordinating Council.

Public Health

As I have already indicated, there are legislative areas of interest and concern to both you and the Department. Among these issues is the revision of Chapter 154, the Florida statute defining our public health program and laying out the relationships between the county health units, the county commissions, and the Department of HRS. We, as you, favor local involvement in the delivery of public health services. The question becomes: What is the best mix of state and local involvement and participation in order to achieve the optimum public health program in Florida? This issue is now under review by Governor Graham, the Advisory Commission on Intergovernmental Relations, relevant legislative committees, and the Department. We expect comprehensive legislation on this subject during the coming session.

There appears to be a definite need for the establishment — in the near future — of a graduate school of public health in Florida. We are having increased difficulty in attracting public health practitioners who are trained in other states' schools of public health. What we are finding is that the states with public health education programs are attracting the lion's share of available resources, especially trained public health physicians and nurses. As you are well aware, where you receive your education and where you do your internship often determines where you ultimately will reside and work.

Dental Health

Another issue which has been debated for some time is that of fluoridation. There is continuing concern on the part of some interests that fluoridation leads to worsened rather than improved health. Yet our neighboring state of Georgia, which adopted a statewide system of fluoridation at the behest of Governor Carter, has not experienced the problems which the opponents of fluoridation have cited. Even if we were to introduce fluoridation in only the major urban areas, we could bring significantly improved dental health to most of Florida's children and youth.

Catastrophic Health Coverage

Another area of concern which will require legislation at either the state or national level is that of

catastrophic health coverage. Your own president, Representative Richard S. Hodes, has — since at least 1973 — sought some relief for citizens in Florida who are faced with catastrophic illness. Again, this year, I would imagine that there would be legislative proposals aimed at addressing what has proved to be the financial ruination of many Florida families.

In conclusion, I want to thank the Florida Medical Association and its staff for working toward improved relationships and open lines of communication with the Department. We do not always agree, but we are communicating. It is certainly my desire that this candor and openness continue and that we work together in partnership to bring better health to the people of Florida.

● Mr. Pingree, 1317 Winewood Boulevard, Tallahassee 32301.

Community Hospital Education Council Increases Preceptor Program Funds

Physicians, especially those in family practice, have been outstanding in their willingness to provide preceptorship training during the summer, according to the report of their response discussed at a meeting of the Community Hospital Education Council in Tampa. Members of the Council noted that 26 students from the University of Miami School of Medicine and eight from the University of Florida College of Medicine were involved in this training last year. They served with primary care practitioners for about five weeks at the end of the first year of medical school. Students from the University of South Florida College of Medicine have not participated because there is no break between the first and second years in the current three-year curriculum.

Council members expressed the opinion that the preceptor should not be obligated for all expenses of the student in addition to instruction and community effort. They, therefore, voted to increase the funds available to the program.

It was begun in 1969 by the American Medical Student Association as the Medical Education and Community Orientation Project to offer students an opportunity to learn about health care in a community. The project is showing increasing value in recruitment of students to primary care specialties through early exposure before specialty orientation captures their interest. Council members have reviewed convincing evidence of early recruitment and the relationship of origin of students to ultimate locations of practice.

A. Joseph Henry Jr., M.D., of Tallahassee was unanimously elected chairman of the Council succeeding Charles J. Kahn, M.D., of Pensacola who has served in this capacity for the past four years.

The Council voted to continue financial support of the Surrogate Patient Teaching Program at Tampa General Hospital and of the residency program at Women's Hospital in Tampa. It approved the request for full funding of three additional pediatric residencies at Jackson Memorial Hospital in Miami, thus increasing the number to 37. The Family Practice Program faculty development grant previously awarded to this hospital was continued. The funds are earmarked for coordination of first year training.

A second faculty development grant requested by the Orlando Regional Medical Center Department of Pediatrics was not approved.

Frank C. Coleman, M.D., Council member from Tampa, reported that the American Medical Association appeared to be moving toward requirement of a general first year for all medical school graduates before specialized training is begun. This could be significant in programs supported by the Council.

C. O. Plyler, M.D., and Mrs. Candice Stewart of Jacksonville reported on the progress of the Family Practice Residency Program special activity among residents designed to improve their awareness and skills in patient education and communications. Dr. Plyler heads the residency program at St. Vincent's Medical Center, and Mrs. Stewart coordinates the education-communication activity which is aided by a Council grant.

The Pensacola Education Program requested clarification of the Council's position relative to "shared-schedule residencies." Council members concluded that "we would consider a full-time equivalent residency position that could be shared between two people until board requirements are met. Of course, each must be half time and make normal progress toward board certification.

EDITORIAL

Individual Involvement

Will Rogers once said, "When I tell a joke everybody laughs, but when the President of the United States or the Congress tells a joke it becomes law." I think that statement is even much more true today than when Will Rogers said it. How can you keep these jokes from becoming funnier every year? You have already taken the first step by membership in your state association and subscribing financially to its operations and to the operations of its Capital Office. Your executive leadership, your Capital Office, your legislative consultants can define the issues, follow their progress or lack of progress through the legislative halls, represent you before the various committees and individuals in the presentation of your program before the Legislature, but that is only half the job. The remainder of the job is up to you as individuals.

If you do not take care of your individual responsibilities with your individual legislator it would be comparable to having the finest equipped hospital, the most modern clinical laboratories, fully trained technicians and diagnosticians, but with no surgeons or physicians to carry out their findings and recommendations.

Consequently, this is the time of year when each of us should determine his responsibility to the profession and to the public in the light of our individual contacts with our particular Representatives or Senators.

If I were to have to choose between having an adequately financed, fully staffed legislative team working with dedicated leadership of the FMA, or the sure knowledge that each of you would make a determined effort to contact his or her individual legislator, I would choose the latter course. Of course, it is best to have both.

Remember, everybody's business is nobody's business. If each of you reading this message will take the responsibility of contacting just one legislator, not two or many, but just one in an effective way, there would be no doubt about your having successful results both in the halls of Congress and in the State Legislature.

W. Robert Fokes, Esq.

Mr. Fokes is an FMA Legislative Consultant in Tallahassee.

While no one should quit because the going gets rough, it may be wise to take a moment and see if there isn't an easier way to reach the same destination.

ORGANIZATION



Richard S. Hodes, M.D.

103rd President of the Florida Medical Association

How does one combine the responsibilities of a president of a major medical association, a leading legislator, a private practitioner, a community leader, and an officer of a national organization? This would seem to be an impossible task, but Dick Hodes has done it. His performance confirms the old adage, "If you want a job well done, get a busy man to do it."

Dick outlined some of his goals for the FMA in his first President's Page in the June 1979 issue of the *FMA Journal*. He noted that an assessment of FMA expenditures was indicated in the presence of an inflating economy, and once this was done, cost reductions should follow. Top management consultants were retained to study the FMA operations, and their recommendations resulted in a reorganization of FMA activities with a significant reduction of staff with no reduction in effectiveness.

In the same article, he noted that a review of the structure and functions of all councils and committees would be made. This review was done in cooperation with the chairmen of them. Some of the councils and committees were reduced in size while others were combined or eliminated. These changes resulted in a notable reduction in FMA costs.

Dick then turned his attention to the ongoing activities of the FMA. Supported by the Board of Governors, councils, committees and staff, he addressed problems of the Medicaid and Worker's Compensation Programs.

While addressing these problems, he was able to bring about a vast improvement in the relationship between the FMA and the State Department of Health and Rehabilitative Services. Through Dick's previous relationship with David Pingree, now the Secretary of the Department of HRS, and the enthusiasm with which Mr. Pingree's appearance and presentation were received before the Fall Board of Governors' meeting whereby he outlined the Department's goals for the Florida Medicaid Program, a new spirit of cooperation was formed and a commitment was made to upgrade the quality of the Medicaid Program and to elevate the level of physician involvement.

This led to actual improvements and reorganization of the Medicaid Program and, further, to negotiations with the FMA Foundation by DHRS to provide administration of the Emergency Medical Services Program and the possibility of the use of the Foundation for other services.

Dick's efforts also resulted in much more equitable reimbursement for physicians participating in the Worker's Compensation Program.

The newly established public relations office of the FMA expanded and stepped up the intensity of public relations. This expansion included scheduled visits to editors and publishers of our major metropolitan newspapers, informing them of FMA goals and programs. A favorable response was received during most of these visits.

Shortly after taking office, Dick requested the Chairman of the Council on Legislation to reorganize the legislative key man system, involve the Auxiliary more actively in FMA legislative efforts, and develop better working relationships on legislative matters with specialty groups. These changes have been accomplished.

He also asked the leadership of FLAMPAC to strengthen its activities by increasing membership, developing working relationships with other appropriate political action committees and expanding its political education programs.

Dick continued the visits to county medical societies that have been traditional for presidents of the FMA.

In anticipation of many troublesome health-related legislative issues in 1980, Dick was deeply involved in the development of the 1980 legislative program of the FMA. This program was approved by the Board of Governors in March 1980. Recovery of costs in civil actions headed the list. This was a timely selection since in late February the Florida Supreme Court struck down the mediation panel law. In a far-reaching opinion, the Court indicated that it did not believe that it was possible by legislative action to correct the inherent constitutional defects existing in the mediation panel concept.

Throughout the year the FMA leadership has been concerned with the many troublesome legal actions involving the FMA. The Internal Revenue Service has attacked the FMA's tax-exempt status. After a detailed investigation, its tax-exempt status was left unchanged. The United States Postal Department attempted to revoke the FMA's special third class mailing permit. This effort failed and the special third class mailing permit was retained. The Antitrust Division of the Department of Justice reviewed many of the files of the FMA to determine whether the FMA had been guilty of restraint of trade. It appears that this investigation will be

terminated without action against the FMA.

A conciliation agreement was finally reached with the Federal Elections Commission over a jurisdictional dispute involving FLAMPAC, the Florida Medical Association, and AMPAC.

A permanent injunction requested by the FMA to prevent Medicare from releasing the names of physicians treating Medicare patients and the amounts received by them was granted. This decision has been appealed by HEW but the outlook for the FMA is favorable.

The FMA is initiating a legal action against the Department of Professional Regulation of Florida to prevent implementation of a provision in the Practice Acts adopted last year requiring physicians to post signs in their offices notifying patients of a toll-free line to Tallahassee which could be used to complain about or question services received from the licensees.

The FMA has been involved in several other legal actions either as a defendant or as a friend of the court but space does not permit a description of them.

Among his other responsibilities, Dick has served as Treasurer of the Florida Physicians' Insurance Reciprocal. He has participated with the other officers and board members of the Reciprocal in increasing physician participation so that there are now over 6,400 physicians insured. Coverge has been maintained at its current level in spite of an increase in frequency and size of claims. The Reciprocal was also able to return a dividend to policyholders of $1 million in 1979.

When Dick was installed as President of the FMA, he was serving as Speaker Pro Tempore of the Florida House of Representatives. He also served as Chairman of the Education Subcommittee of the House Appropriations Committee. As chairman of this subcommittee he has jurisdiction over the budgets of all of the educational institutions in Florida funded by the state. He has just recently directed an oversight study of legislative concerns about education in Florida's public schools. This involved visits to 68 public schools in 10 Florida school districts. His other committee assignments included membership on the Rules and Calendar Committee and the Finance and Tax Committee. He has served as chairman of Florida's nationally known legislative intern program for over eight years.

Dick also sponsored legislation to establish the Eminent Scholars Endowed Chair Program for the State Universities. Two endowed chairs of $1 million each have been established at the University of Florida so far. These are a chair in the School of Business and a chair for the study of human nutrition. The chairs have been endowed since the passage of the legislation in June 1979. He also had a leadership role in establishing an endowment matching fund for New College of Sarasota, a branch of the University of South Florida.

As a practicing physician, Dick is in demand as an anesthesiologist in Tampa and is maintaining an active practice.

As a community leader, Dick has a weekly educational television program on Channel 3 in Tampa. The program focuses on current issues and is an interview program which reaches audiences within a 15-county radius. He has made numerous trips to Washington to represent legislative organizations, the legislature, and the people of Florida in discussions with federal officials and congressional committees on such activities as our Vocational Rehabilitation Program and the development of the federal budget. On several of these trips he met personally with President Carter.

Dick has been active for the past several years in the National Conference of State Legislatures, an association involving 7,500 state legislators. This year he has served as President-elect of the organization and will assume the presidency at its upcoming annual meeting in July. As part of his activities with the National Conference he has participated in meetings with the Commonwealth Parliamentary Association in Quebec and Palm Beach and is undertaking to help organize a Caribbean Parliamentary Association made up of Caribbean nations and southern coastal states. This organization will have as one of its goals the demonstration to developing Caribbean nations of how various representative democracies work.

It is obvious that Dick Hodes has had a very busy year. He has indeed provided a role model for all of us to follow.

"The worth of a state in the long run is the worth of the individuals composing it."

— *John Stuart Mill*

F. C. Coleman, M.D.
Tampa

All wise men share one trait in common: the ability to listen.

Frank Tyger



The End of an Era

Having had a paper published before entering medical school and on the editorial boards of *Clinical Pediatrics* and *The Journal,* making him no stranger to medical literature; having been involved in publishing 80 papers and several books, making him grounded in the basics of scientific writing; and having been a teacher well versed in administrative affairs as Chairman of his department; Gerold Schiebler was extremely qualified to assume the position as Editor of *The Journal* in 1975. Commuting often between Gainesville and Jacksonville to solve the problems of monthly pubication, he still found time to guide and direct pediatrics at the medical school, serve as a member of important committees of his county and state medical societies and governmental agencies in Tallahassee. In his second year as Editor, he gave the annual Grover F. Powers memorial lecture at Yale University. The following year, he received the President's Award of the Florida Affiliate of the American Heart Association, and last year he was listed by *Harper's Bazaar* as one of the country's outstanding pediatric cardiologists.

The Journal, as one of many FMA creative activities, has as its special contribution, the art of communication, a vitally important act to be cultivated and refined. For often, lack of understanding, parochial rivalry or unjustified criticism makes it difficult to get physicians to work together, and is due to poor or inadequate communication. Due to failure to utilize this contribution, or in other words, the failure to get physicians to read *The Journal,* is something Dr. Schiebler has worked long and hard to correct. The challenge to him every month was to produce a creative,

expressive and ever-new view of the true aims and views of our profession and its members.

As Editor of *The Journal* he controlled the sluice gates of publication but operated under certain pressures. He must receive an adequate number of manuscripts from which to choose and his choice must enhance the prestige of *The Journal* and increase its readership. To do this, he critically evaluated both the content and the form of the manuscripts submitted for which he has received active participation from some 10 percent of the members of the FMA as referees to help him determine the merits of any given paper. How to reject an original manuscript and still retain Journal support and friendship from a private practitioner is one of the hardest tasks of an editor. This, Dr. Schiebler did with agony as do all editors.

Publishing a Journal costs money. Much of this money comes from advertising revenue, some from the FMA and some from individuals and organizations who produce special issues. To ensure publication of the first of these, it appeared that Dr. Schiebler would have to draw on his personal bank account but with experience and explicit guidelines, these issues were funded by their contributors. During his tenure, 22 such special issues were published, many of them receiving awards from other organizations and for which requests for extra copies came from medical students, volunteer health agencies and even the American Medical Association. Other commendable additions by the Editor have been the insertion of quarterly reports of the meetings of the Board of Governors; regular pages provided for groups such as Emergency Medical Services, State Health Agencies and FMA Committees and Councils. In 1979 the Editor initiated a workshop for county society bulletin editors. This has been, during each of the past two years, an enthusiastically attended affair where instructions on the art of medical writing and publishing were conducted by professors of journalism.

Nevertheless, even with the best intent in the world, Dr. Schiebler has not always been able to produce the kind of Journal he wished. Space in *The Journal* is limited. How to use that space to the best advantage, he has had to decide according to his own likes and must determine what best promotes the interest of the Florida Medical Association according to his own scheme of values. Editors do not own the journals they edit. The publisher, in this case the FMA, owns the publication and the editor is an appointee of the Board of Governors, which empowered by the House of Delegates, sets the policies to which an editor must adhere. Dr. Schiebler, however, as a good editor can do, oftentimes persuaded the Board to see things his way. He found out that he could not please everyone but as he must please himself; that is, stick to his own values; so with the help of the full time staff, he was able to instigate his own values in medical literature and markedly elevate the standards of medical writing in Florida.

Other material changes have taken place in *The Journal.* More legible type was developed. The logo on the cover was changed and pictures and art work graced each cover. The editor's purpose was often to use the cover as an illustration for the leading article, and he was, justifiably proud of these covers, especially so each December when there appeared a Christmas theme designed by a friend of the editor, named Audrey.

The Editorial Board, his brothers of the mind through mutual admiration and common ideals, profoundly impressed by his dedication, his many hours of work, his attention to detail, his continuing philosophical exploration into the purposes of a state publication, his rapport with the student editors and the esteem of his residents, congratulate him and wish him success in all his future endeavors.

In the years to come Dr. Schiebler can look back with pride on his years of editorship. Five bound volumes of *The FMA Journal* in medical libraries over the country will always attest to his untiring efforts in publishing a superior state journal.

C.M.C.

Do what you can, with what you have, where you are. — Teddy Roosevelt

Dr. Deal Resigns U. of F. Vice Presidency To Accept AMA Position



Dr. Deal

William B. Deal, M.D., has resigned as Vice President for Health Affairs and Dean of the College of Medicine at the University of Florida, effective July 2. He will assume a high level position with the American Medical Association.

University President Robert Q. Marston, M.D., announced that the positions of Vice President and Dean will be separated. A committee headed by William C. Ruffin, M.D., Professor of Psychiatry and Chief of Staff of Shands Teaching Hospital, will search for a new Dean.

A search committee for a new Vice President for Health Affairs has not been appointed as this issue of *The Journal* went to press.

When Dr. Deal leaves, Kenneth Finger, Ph.D., will become Acting Vice President for Health Affairs, and J. Lee Dockery, M.D., will serve as Acting Dean, the University announced. Dr. Ruffin will become Acting Associate Vice President for Health Affairs, a position now held by Dr. Finger.

Dr. Dockery, a member of the Executive Committee and Board of Governors of the Florida Medical Association, currently is Associate Dean for Academic Affairs.

Dr. Deal, 43, will become a Senior Vice President of the American Medical Association in Chicago and will work in the area of education and scientific activities. He was one of two Florida physicians appointed last fall to the AMA's new Committee on Accreditation of Continuing Medical Education.

A native of North Carolina, Dr. Deal graduated from the University of North Carolina College of Medicine in 1963, and took internship, internal medicine residency and a fellowship in infectious diseases at Shands Teaching Hospital in Gainesville.

Dr. Deal was an Associate Dean at the University of Florida under the late Dr. Chandler A. Stetson, who held both the vice presidential and dean's titles. Dr. Deal became Acting Dean during Dr. Stetson's final illness in April of 1977.

Dr. Stetson, who was both Dean and Vice President for Health Affairs, died in May of 1977.

In April of 1978, Dr. Marston announced Dr. Deal's appointment as both Dean and Vice President for Health Affairs.

The Vice President has administrative and operational responsibility for Shands Hospital and the Colleges of Medicine, Nursing, Pharmacy, Dentistry, Health Related Professions, and Veterinary Medicine.

It is not in doing what you like, but liking what you do that is the secret of happiness.

James Barrie

Solutions '80
1980 Florida Medical Association Legislative Program

"PLI Crisis Looming"

"Application of its rigid jurisdictional periods have proven arbitrary and capricious in operation yet the act cannot be remedied by escalating the jurisdictional period or in permitting continuances or extension of time for to do so would constitute a denial of access to the courts. We are left then with a statute which is intractably and incurably defective and therefore hold the mediation panel act as unconstitutional in its entirety as violative of the due process clauses of the United States and Florida State Constitutions." With this language, the Florida State Supreme Court, on February 28th, struck down Florida's Mediation Statute. This unfortunate ruling was to aggravate an already developing air of imminent crisis in the field of medical professional liability insurance in Florida of potentially even greater proportions than existed during the PLI crisis in 1975.

The ruling was so sweeping as to leave virtually incurable by legislative act, the high courts perceived, constitutional defects in the mediation statutes. Thus was lost perhaps the most successful provision of the tort reforms enacted by the 1975 Florida Legislature, a provision which served to dispose of the great majority of non-meritorious claims in a more expedient and less expensive manner than a circuit court trial. The potential magnitude of the negative impact of the ruling on the cost and even the availability of insurance to Florida's physicians is cause for grave concern. At the very least, insurance rates that had been stabilized are now vulnerable to dramatic increases. The reasonable cost and availability of reinsurance for the Florida Physicians' Insurance Reciprocal through Lloyds of London is threatened. Moreover, loss of the mediation panel, coupled with a current and projected escalation in the number of claims filed and the cost of settling a claim indicate serious problems in the immediate future.

The future of malpractice insurance is clearly in jeopardy and the FMA once again must call upon the Florida Legislature for assistance in enacting legislation to provide for a stabilized environment in which, quality insurance protection can be made available to physicians in Florida, and in which the least costly and most efficient health care delivery system can be assured for Florida citizens.

It appears that the most effective solution to the problem would be passage of legislation to provide for the recovery of costs in all civil proceedings (not just malpractice). Proposed legislation, HB 1133 and SB 762 which is being sponsored by the FMA has been introduced for consideration during the 1980 Session of the Florida Legislature. Expedient approval of the bill is vital to restoring stability in the professional liability insurance market in Florida and the FMA is employing every reasonable asset and resource of the Association to bring about its passage. The concept also has widespread support among allied groups, business and professional organizations.

The bill provides "the court shall award a reasonable attorney's fee to the prevailing party in any civil proceeding." To insure equal access to the courts, the bill also provides "that attorney's fees shall not be awarded against a party that is insolvent or poverty stricken." In addition, "before initiating a civil proceeding on behalf of a client, it shall be the duty of every attorney to inform the client, in writing of the provision of this section."

This proposed legislation is a major structural reform that will serve to equalize the standing of the plaintiff and the defendent in terms of the financial risks involved in going to trial in any civil proceeding. The long range implications of its successful passage or failure to either the future stability, or rampant escalation of premiums for professional liability insurance, and ultimately the ability of physicians to provide cost effective and uninterrupted medical care cannot be over estimated. These same financial implications extend to virtually every segment of business in our society as it effects the cost of goods and services.

Other Legislative Concerns

The FMA has, and will continue to support legislation and programs that enhance delivery of the highest quality health care for Floridians at the lowest possible cost. A number of issues that are currently under consideration by Florida Legislature could effect the quality, delivery and cost of health care service in Florida.

Proposals have been made to dismantle the current county health system and replace it with regional departments under direct control of the Department of HRS. The FMA is a strong advocate for retention of county health units with local control and citizen input and is opposed to any state assumption for responsibility of this important function.

The Association is aware of the continuing concern of increases in health care costs and will continue to actively support and participate in the successful voluntary effort to control these costs while preserving the free enterprise system of health care delivery. The FMA will support additional efforts to control costs which are consistent with the Association's formal position on the cost of medical care. Among such proposals that appear to be appropriate are: Deductibles and co-insurance provisions in all health insurance contracts; equal consideration for out-patient surgical and diagnostic services; minimum standards for health insurance contracts; expansion of catastrophic health insurance coverage and requirements for health cost impact studies for proposed state rules and regulations. The FMA opposes further regulation of the private health care community.

The Association supports increased funding for physician services with emphasis on out-patient care in Florida's Medicaid, vocational rehabilitation, and children's medical service programs. FMA also supports increased funding for an improvement in Florida's public heath and mental health programs as well as legislation relating to confidentiality of medical records.

—Donald C. Jones
FMA Executive Director

Southern Ob-Gyn Seminar Set for July In Asheville, N.C.

The Southern Obstetrics and Gynecology Seminar will be conducted July 20-25 at the Grove Park Inn, Asheville, N.C.

The program has been designated for 22 hours of AMA Category I Credit. Information may be obtained by contacting George T. Schneider, M.D., Secretary, Southern Ob-Gyn Seminar, 1415 Jefferson Highway, New Orleans, La. 70121.

It is one of the most beautiful compensations of this life that no man can sincerely try to help another without helping himself.

Emerson



Louise Rader

For the first time in over a decade, this issue of *The Journal* does not carry on its masthead the name of Louise Rader as Managing Editor. For during this time she has, and for more than a quarter of a century, been responsible for seeing month after month that the official publication of the Florida Medical Association was sent to the printer and mailed to physicians all over the State.

Planning to work just for a few months over 25 years ago, but somehow never finding time to quit, she often attended the FMA Annual Meeting and had the unique opportunity of knowing or working with every Editor except one -- Dr. E.W. Warren from Palatka, who was appointed interim editor in 1918 during World War I.

Over 300 interesting issues just didn't happen, but resulted from many hours of attending to little details, and were products of constantly striving for fine literary qualities, constructive thinking and unusual accomplishments.

The sketch above by one of our favorite physician artists will enshrine her forever among the luminaries of *The Journal*, but will never displace the image of her in the mind's eye and hearts of her many physician friends and FMA staff members.

C.M.C.

The above composite was drawn by John W. Snow, M.D., a Jacksonville plastic surgeon.

Annual Report

Florida Medical Association Auxiliary

Mrs. B. David Epstein

Our Auxiliary theme this year was "Pearls of Wisdom, Communication, Education and Motivation," and to this end we dedicated ourselves.

We communicated our desires, ambitions, knowledge and expertise to all three levels of the Auxiliary. We educated our members and communities to our common needs and concerns, and motivated our members to help solve some of these problems by becoming actively involved in our varied programs and projects.

MEMBERSHIP: Our energetic Membership Committee was responsible for a 5 per cent increase — bringing our total in excess of 5,000. If we can increase an additional 5 per cent, we will be eligible for a membership award at the National Convention in July. An AD HOC committee on branching was formed to make an indepth study and offer assistance. All county and branch by-laws were submitted to the By-laws Committee to identify and determine any conflicts with state and national by-laws. A student and intraining category was added to the membership requirements. We honored and celebrated Doctors' Day in March and contributed materials to Auxiliary and Society publications.

CONTRIBUTIONS: Our fund raising efforts produced to date approximately $50,000 for AMA-ERF and $7,000 for FMF designated for the Impaired Physician Program and $5,000 for IH activities. Thank you for your generosity.

LEGISLATION: We have taken a more positive role in political education and political action. Many Auxilians serve on state and county society legislative committees and candidate selection committees; many more are actively involved in the legislative alert system.

CHILD ABUSE PREVENTION: Our Child Abuse Prevention Program is far-reaching. In addition to distributing brochures to service organizations and physicians, we are in the process of distributing brochures to all the schools in the state (K-6th grade). Many members serve on task forces and participate in free-parenting and parenting classes and parents anonymous activities. Still more serve in social service oriented capacities.

IMPAIRED PHYSICIAN: A questionnaire dealing with the Impaired Physician was mailed to all Auxiliary members. A profile of the physician, spouse and family has been described and will serve as a vital educational tool. Thank you to all who took the time to read and respond.

HEALTH EDUCATION: In keeping with the FMA theme of nutrition and physical fitness, we adopted the AMA Auxiliary's "Shape Up For Life" campaign. In addition to the varied ways this was presented, the logo was imprinted on milk cartons throughout the state. Several worry clinics, crises and awareness seminars were held in many counties. We assisted in the planning of a School Health Conference to be held October 1980 in Orlando and also serve on a task force to establish a Florida Center for health education. A seminar is scheduled for June 1980.

It was a privilege to visit so many counties throughout the State and to represent the Auxiliary at other state and national meetings. It has indeed been an honor to serve as president. Thank you for your enthusiastic support and encouragement, for your participation and talents, and most of all, for your cherished friendship. In short, thank you for a "Pearl" of a year.

Mrs. Epstein, Florida Medical Association Auxiliary President 1979-1980.



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DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male. 1. Eunuchoidism and eunichism. 2 Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to endrogenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and nses in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any chenges in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present e problem, especially in patients with compromised cerdiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovescular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma ot the mele breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexuel stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexuel development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jeundice • Oligospermia and decreesed ejaculatory volume • Hypercelcemia particularly in patients with metestatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, es patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as en average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg ; Mele climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.. Postpuberel cryptorchism, 30 mg. **REFERENCE:** R. B Greenblett, M.D., R. Witherington, M.D ; I. B. Sipahioglu, M.D. Hormones for Improved Sexuality in the Male and the Female Climecteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only

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Book Reviews

Book Review Editor
F. Norman Vickers, M.D.

Barron's Guide to Financial Aid for Medical Students by Steven H. Lazar, M.D. 160 Pages. Price $5.95. Barron's Educational Series, Inc., Woodbury, New York, 1979.

This book was designed by a medical school financial aid director to assist students entering or enrolled in medical school with sources and procedures for receiving financial aid. The author attempts to list all national and state programs which include scholarships, loans, grants, prizes, and other monetary awards. Also included are basic procedures followed by most schools in application and administration of financial aid, and a list of the addresses of every medical school financial aid office in the United States.

The author recommends that students contact their particular schools of interest for further information about financial aid at that school and in that state.

Students who follow this approach are likely to gather more valuable information from the schools directly than from the *Barron's Guide*. In fact, the financial aid director at my own school noted several areas where the information in *Barron's Guide* was either incomplete or incorrect.

A list of small, usually highly selective sources of aid throughout the nation is perhaps the only information in Barron's which an individual school's financial aid officer may not be aware. The *Guide* lists basic descriptions of these programs and supplies addresses to which students can refer for details. The relative paucity of such sources which apply to any individual student however, does not warrant the recommendation of this book to all students.

Recommended for medical school financial aid directors; students should consult the school financial aid director first rather than this book.

James Deming
Miami

Mr. Deming is a medical student at the University of Miami School of Medicine and a consulting editor of the *Journal*.

Books Received

Receipt of the following books is acknowledged. Medical readers interested in reviewing particular books are invited to address requests to the Book Review Editor. Following acceptance of a written review for publication, a reviewer may then retain the book reviewed for his personal or favorite library.

The Chemistry of Human Behavior by Herbert L. Meltzer, Ph.D. 261 Pages. Illustrated. Price $17.95 (cloth). Nelson-Hall Publishers, Chicago, 1979.

Annual Review of Neuroscience with 31 contributing authors. 555 Pages. Annual Reviews, Inc., Palo Alto, California, 1979.

Norethindrone, The First Three Decades edited by Mary Jean Pramik. 100 Pages. Syntex Laboratories, Palo Alto, California, 1978.

How To Improve Your Child's Behavior Through Diet by Laura J. Stevens and Rosemary B. Stoner. 346 Pages. Price $9.95. Doubleday & Company, Inc., New York, 1979.

Child Guidance by Samuel Kahn, M.D., Ph.D., F.R.S.H. 134 Pages. Price $10.00. Philosophical Library, Inc., New York, 1979.

The Vitamin Book by Rich Wentzler. 224 Pages. Price $4.95. Doubleday & Company, Inc., New York, 1979.

The Truth About Senility — And How To Avoid It by Lawrence Galton. 244 Pages. Price $9.95. Thomas Y. Crowell Company, New York, 1979.

Clinical Anxiety/Tension in Primary Medicine: Proceedings of a Colloquium, Washington, D.C., Excerpta Medica, Lawrenceville, N.J.

Current Medical Diagnosis and Treatment by Marcus A. Krupp, M.D. and Milton J. Chatton, M.D. 1116 Pages. Price $19.00. Lange Medical Publications, Los Altos, California, 1980.

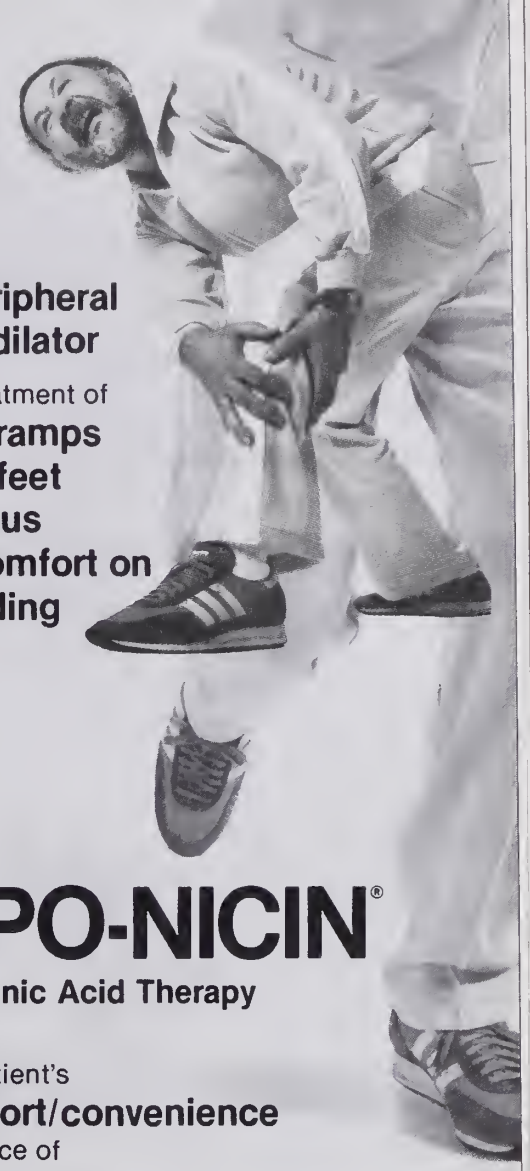
Currents in Alcoholism, Vols. 3 and 4. Edited by Frank A. Seixas, M.D. 1099 Pages. Price $31.50 and $26.50. Grune & Stratton, Inc., New York, N.Y.

Handbook of Pediatrics by Henry K. Silver, M.D.; C. Henry Kempe, M.D. and Henry B. Bruyn, M.D. 730 Pages. Price $9.50. Lange Medical Publications, Los Altos, California, 1980.

Handbook of Poisoning, Tenth Edition, by Robert H. Dreisback, M.D. 578 Pages. Price $9.50. Lange Medical Publications, Los Altos, California, 1980.

General Ophthalmology, Ninth Edition, by Daniel Vaughan, M.D. and Taylor Asbury. 410 Pages. Price $15.00. Illustrated. Lange Medical Publications, Los Altos, California, 1980.

Annual Reviews Reprints: Immunology, 1977-1979, compiled by Irving Weissman. 466 pages. Illustrated. Annual Reviews, Palo Alto, California, 1980.



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Pyridoxine HCL (B-6) .....10 mg.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500.

LIPO-NICIN®/100 mg.

Each blue tablet contains:
Nicotinic Acid .....100 mg.
Niacinamide .....75 mg.
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Thiamine HCL (B-1) .....25 mg.
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Pyridoxine HCL (B-6) .....10 mg.
DOSE: 1 to 5 tablets daily.
AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN® 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient.

Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur.

Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

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Brief Summary of Prescribing Information

Indications and Usage: Symptomatic relief of anxiety, tension, agitation, irritability and insomnia associated with anxiety neuroses and transient situational disturbances; anxiety associated with depressive symptoms and as a treatment of symptoms of anxiety if such symptoms are a significant feature of functional or organic disorders, particularly gastrointestinal or cardiovascular

Effectiveness in long-term use, i e , more than 4 months, has not been assessed by systematic clinical studies Reassess periodically usefulness of the drug for the individual patient.

Contraindications: Known sensitivity to benzodiazepines or acute narrow-angle glaucoma

Warnings: Not recommended in primary depressive disorders or psychoses. As with all CNS-acting drugs, warn patients on lorazepam not to operate machinery or motor vehicles, and of diminished tolerance for alcohol and other CNS depressants.

Physical and Psychological Dependence. Withdrawal symptoms like those noted with barbiturates and alcohol have occurred following abrupt discontinuance of benzodiazepines (including convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Addiction-prone individuals, e g drug addicts and alcoholics, should be under careful surveillance when on benzodiazepines because of their predisposition to habituation and dependence Withdrawal symptoms have also been reported following abrupt discontinuance of benzodiazepines taken continuously at therapeutic levels for several months

Precautions: In depression accompanying anxiety, consider possibility for suicide.

For elderly or debilitated patients, initial daily dosage should not exceed 2mg to avoid oversedation

Terminate dosage gradually since abrupt withdrawal of any antianxiety agent may result in symptoms like those being treated anxiety, agitation, irritability, tension, insomnia and occasional convulsions

Observe usual precautions with impaired renal or hepatic function.

Where gastrointestinal or cardiovascular disorders coexist with anxiety, note that lorazepam has not been shown of significant benefit in treating gastrointestinal or cardiovascular component

Esophageal dilation occurred in rats treated with lorazepam for more than 1 year a 6mg kg day No effect dose was 1 25mg/kg/day (approximately 6 times the maximum human therapeutic dose of 10mg/day) Effect was reversible only when treatment was withdrawn within 2 months of first observation Clinical significance is unknown; but use of lorazepam for prolonged periods and in geriatric patients requires caution and frequent monitoring for symptoms of upper G I disease

Safety and effectiveness in children under 12 years have not been established

ESSENTIAL LABORATORY TESTS Some patients have developed leukopenia, some have had elevations of LDH As with other benzodiazepines, periodic blood counts and liver function tests are recommended during long-term therapy

CLINICALLY SIGNIFICANT DRUG INTERACTIONS. Benzodiazepines produce CNS depressant effects when administered with such medications as barbiturates or alcohol

CARCINOGENESIS AND MUTAGENESIS No evidence of carcinogenic potential emerged in rats during an 18-month study No studies regarding mutagenesis have been performed.

PREGNANCY Reproductive studies were performed in mice, rats, and 2 strains of rabbits Occasional anomalies (reduction of tarsals, tibia, metatarsals, malrotated limbs, gastroschisis malformed skull and microphthalmia) were seen in drug-treated rabbits without relationship to dosage Although all these anomalies were not present in the concurrent control group, they have been reported to occur randomly in historical controls. At 40mg/kg and higher, there was evidence of fetal resorption and increased fetal loss in rabbits which was not seen at lower doses Clinical significance of these findings is not known However, increased risk of congenital malformations associated with use of minor tranquilizers (chlordiazepoxide, diazepam and meprobamate) during first trimester of pregnancy has been suggested in several studies Because use of these drugs is rarely a matter of urgency, use of lorazepam during this period should almost always be avoided Possibility that a woman of child-bearing potential may be pregnant at institution of therapy should be considered Advise patients if they become pregnant to communicate with their physician about desirability of discontinuing the drug

In humans, blood levels from umbilical cord blood indicate placental transfer of lorazepam and its glucuronide

NURSING MOTHERS It is not known if oral lorazepam is excreted in human milk like other benzodiazepines As a general rule, nursing should not be undertaken while on a drug since many drugs are excreted in milk.

Adverse Reactions, if they occur, are usually observed at beginning of therapy and generally disappear on continued medication or on decreasing dose. In a sample of about 3,500 anxious patients, most frequent adverse reaction is sedation (15 9%), followed by dizziness (6 9%) weakness (4 2%) and unsteadiness (3 4%) Less frequent are disorientation, depression, nausea change in appetite, headache, sleep disturbance, agitation, dermatological symptoms, eye function disturbance, various gastrointestinal symptoms and autonomic manifestations Incidence of sedation and unsteadiness increased with age Small decreases in blood pressure have been noted but are not clinically significant, probably being related to relief of anxiety.

Overdosage: In management of overdosage with any drug, bear in mind that multiple agents may have been taken. Manifestations of overdosage include somnolence, confusion and coma Induce vomiting and/or undertake gastric lavage followed by general supportive care, monitoring of vital signs and close observation Hypotension, though unlikely, usually may be controlled with Levarterenol Bitartrate Injection U.S P Usefulness of dialysis has not been determined

Ativan® (lorazepam) IV for Anxiety

Dosage: **Individualize for maximum beneficial effects. Increase dose gradually when needed, giving higher evening dose before increasing daytime doses. Anxiety, usually 2-3mg/day given b.i.d. or t.i.d.; dosage may vary from 1 to 10mg/day in divided doses. For elderly or debilitated, initially 1-2mg/day; insomnia due to anxiety or transient situational stress, 2-4mg h.s.**

How Supplied: **0.5, 1.0 and 2.0mg tablets.**

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Why one benzodiazepine and not another?

Are you concerned about long-acting metabolites? Many clinicians, as well as pharmacologists, are beginning to draw attention to this problem (see New England Journal of Medicine, April 5, 1979).

In contrast to some older benzodiazepines, Ativan (lorazepam) does not give rise to long-lasting active metabolites. As with all benzodiazepines, you should follow the usual precautions concerning co-administration with other CNS depressants and warn your patients against operating dangerous machinery and motor vehicles.

However, it is noteworthy that Ativan showed no clinical evidence of accumulation even when given in high doses over periods up to 6 months. The half-life of free lorazepam is about 12 hours; steady-state serum levels are attained in 2-3 days. Comparable data for diazepam: 20-50 hours and at least 7-10 days. (The pharmacokinetic profile of a drug can define such characteristics as absorption, distribution, metabolism and elimination but cannot, at present, be directly related to its therapeutic effectiveness.)

Ativan has a convenient b.i.d. or t.i.d. dosage schedule; it is compatible with a long list of other medications and, of course, it is a highly effective anxiolytic agent, as established in numerous nationwide, double-blind, controlled evaluations in thousands of patients.



See important information on preceding page.

Ativan® (lorazepam) for Anxiety

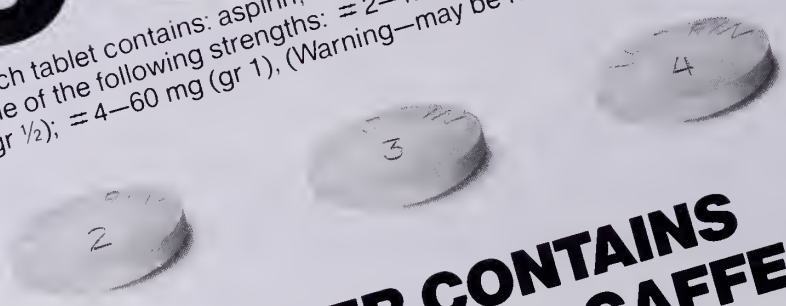
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Librax®

Please consult complete prescribing information, a summary of which follows:

* **Indications:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:
"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.
Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma, prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl/Roche) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated, avoidable in most cases by proper dosage adjustment but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets

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DEPARTMENT OF INTERNAL MEDICINE

SEVENTH ANNUAL REVIEW COURSE FOR CERTIFICATION IN INTERNAL MEDICINE

"FUNDAMENTAL AND CLINICAL ASPECTS OF INTERNAL MEDICINE"

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Director: Daniel H. Mintz, M.D.
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This course is designed primarily for physicians who are preparing for *certification or recertification in internal medicine.* It will provide an intensive survey of those aspects of internal medicine which should be familiar to internists qualified for certification. Pertinent basic and core information followed by a survey of recent clinical advances needed for effective patient care will be presented. Twelve printed texts, references and self-assessment questionnaires will be provided to all registrants. Pictorial quizzes, patient management problems, videotape symposia and audiovisual teaching aids will be offered throughout the meeting. Upon request the twelve textbooks and self-assessment questionnaires will be forwarded to each registrant before the course begins. This course will end 24 days prior to the certification examination of the American Board of Internal Medicine, thereby providing time for assimilation.

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For registration and information write to:

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*Includes tuition, set of textbooks, self-assessment questionnaires, use of audio-visual aids, library loan of T.V. tapes, cassette tapes and sets of slides.

MEETINGS

Accepted by the FMA Committee on Continuing Medical Education for Mandatory Credit

JUNE

Bascom Palmer Eye Institute, Resident's Day, June, Miami.*

Annual Homecoming in Psychiatry, June, Miami.*

Cardiology for the Practitioner, June 4-6, The Breakers, Palm Beach.**

31st Annual Scientific Assembly, June 11-15, Marco Beach Hotel, Marco Island. For information: Edwin W. Turner, M.D., c/o Florida Academy of Family Physicians, 4057 Carmichael Avenue, Suite 229, Jacksonville 32207.

Hypertension, June 12, Friar Tuck Restaurant, Brooksville. For information: Edward B. Smith, M.D., Citrus Memorial Hospital, Inverness 32650.

Fifth Annual Florida Suncoast Pediatric Conference, June 15-18, Sheraton Sand Key Hotel, Clearwater. For information: Donald I. Macdonald, M.D., 801 Sixth St., S., St. Petersburg 33701.

Immunoanalytical Techniques in Clinical Chemistry, June 20, Florida Junior College of Jacksonville, North Campus, 4501 Capper Road. For information: American Society of Clinical Pathologists, Education Center, Workshop Registration, Box 12075, Chicago, Illinois 60612

MKSAP-V (Internal Medicine Review) (American College of Physicians), June 23-27, The Dutch Inn, Lake Buena Vista.**

JULY

Clinical Management of Coronary Disease and Exercise Testing, July 11-13, Orlando Hyatt, Kissimmee. For information: International Medical Education Corp., Division of Postgraduate Education, Dept. 12, 64 Inverness Dr., E., Englewood, Colorado 80112.

Ventricular Arrhythmias, July 14, Citrus Memorial Hospital, Inverness. For information: R. Edward Dodge Jr., M.D., 511 W. Highland Blvd., Inverness 32650.

5th Canadian Summer Workshop in EKG, July 19-22, Edmonton, Alberta, Canada, For information: Henry J. L. Marriott, M.D., Rogers Heart Foundation, St. Anthony's Hospital, St. Petersburg 33705.

Dermatopathology Seminar and Slide Conference, July 26-27, Breaker's Hotel, Palm Beach. For information: C. Fenner McConnell, M.D., 5151 N. 9th Ave., Pensacola 32504.

AUGUST

Fundamental and Clinical Aspects of Internal Medicine, Aug. 1980.*

Recent Advances in Medicine, Aug. 11-12, Orlando Hyatt Hotel, Kissimmee. For information: Emelie H. Ongcapin, M.D., St. Barnabas Medical Center, Dept. of Pathology, Old Short Hills Road, Livingston, New Jersey 07039.

EKG Interpretation and Arrhythmia Management, Aug. 22-23, Dutch Inn, Lake Buena Vista. For information: International Medical Education Corp., Division of Postgraduate Education, Dept. 12, 64 Inverness Dr., E., Englewood, Colorado 80112.

18th Annual Seminar in Cardiology, Aug. 30-Sept. 6, Copenhagen, Denmark. For information: Henry J. L. Marriott, M.D., Rogers Heart Foundation. St. Anthony's Hospital, St. Petersburg 33705.

SEPTEMBER

Dermatology in Florida, Sept. 8, Citrus Memorial Hospital, Inverness. For information: R. Edward Dodge Jr., M.D., 511 W. Highland Blvd., Inverness 32650.

Neurology for Neurologists, Sept. 25-27, Palm Beach. For information: Stephen A. Shaivitz, M.D., 3701 Broadway, West Palm Beach 33407.

OCTOBER

Echocardiography In-Service Workshop, Oct. 20-24, University of Miami, Jackson Memorial Medical Center, Miami.*

21st Workshop in EKG for Nurses and Physicians, Oct. 30-Nov. 3, Sheraton Sand Key Hotel, Clearwater Beach. For information: Henry J. L. Mariott, M.D., St. Anthony's Hospital, St. Petersburg 33705.

NOVEMBER

Vascular Lesion of CNS, Nov. 10, Citrus Memorial Hospital, Inverness. For information: R. Edward Dodge Jr., M.D., 511 W. Highland Blvd., Inverness 32650.

Clinical Management of Coronary Disease and Exercise Testing, Nov. 14-16, Orlando Hyatt, Kissimmee. For information: International Medical Education Corp., Division of Postgraduate Education, Dept. 12, 64 Inverness Dr., E., Englewood, Colorado 80112.

***For information: Contact Division of Continuing Medical Education, D23-3, University of Miami School of Medicine, P.O. Box 016960, Miami 33101. Tel. (305) 547-6716.**

****For information: Contact Division of Continuing Education, Box J-233, J. Hillis Miller Health Center, Gainesville 32610. Tel. (904) 392-3143, or 392-3183.**

+For information: Contact Janifer M. Judisch, M.D., CME, University of South Florida, Tampa 33620. Tel. (813) 974-2196.

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8. Pregnancy Induced Hypertension
9. Care of Tiny Infants and Their Families
10. Effects of Drugs on Pregnancy, Labor and Lactation

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REGISTRATION FORM

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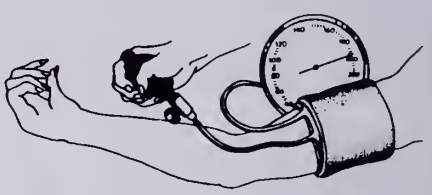
Detach and Mail Check To: **7th Annual Perinatal Conference, c/o Richard J. Boothby, M.D., 5720 Atlantic Boulevard, Jacksonville, Florida 32207. Phone: (904) 725-1600.**

MEDICAL MESSAGE from the Florida Doctors

BLOOD PRESSURE

What is blood pressure and why should you be concerned about it? It is the force with which blood pushes against the walls of your blood vessels and the higher it is, the shorter your life expectancy.

Blood pressure is actually determined by the size, age, and condition of the arteries. This is governed by a system of hormones and chemicals and certain nerve cells that try to keep pressure fairly steady. If it climbs too high, strokes, heart failure or a fatal heart attack are highly possible. On the other hand, low blood pressure generally means you have nothing to be concerned over and can mean a much longer life.



Defining high blood pressure brings up the word "hypertension." That is when the arteries tighten up permanently because something is wrong with the system that regulates their normal size. Many times there can be another disease that causes blood pressure to increase and when that is treated, blood pressure returns to normal.

The doctors of Florida want you to know whether or not you have high blood pressure. Most often a reading of 120/80 is considered normal while 160/95 indicates that blood pressure is too high. However, your age, medical history, and the condition of your arteries are all factors a physician considers in diagnosing an individual case.

A thorough examination can show if you have hypertension and how far it has progressed. Doctors will check your eyes with a bright light to see how much the arteries in the eyes — and thus others throughout the body — have hardened. Urinalysis or blood tests can point up any kidney damage by hypertension and an electrocardiogram or chest x-ray will tell if your heart has been damaged. Your physician will then be in a position to prescribe proper treatment.

The first part of the problem is to admit it if you have hypertension and then do something about it. High blood pressure cannot be cured, but it can be controlled, and the risks of complications reduced.

This is a medical message from the Florida Medical Association in behalf of the doctors of Florida and as a public service feature of this newspaper.

CLASSIFIED ADS

Physicians Wanted

FAMILY PRACTITIONER OR INTERNIST wanted to share facilities with three practitioners in solo practice. Major equipment provided. Rent $250 per month. Competent laboratory and x-ray departments with income based on use. Bookkeeping system and receptionist shared. Contact: T.C. Kenaston Jr., M.D., P.O. Box 550, Cocoa, Florida 32922.

EMERGENCY PHYSICIANS for position with young expanding group. Liberal salary package. Send CV to I. Bloomfield, M.D., Medical Director, P.O. Box 160132, Snapper Creek Station, Miami, Florida 33116 or call (305) 596-2896.

WANTED: Primary care and subspecialty physicians to join multispecialty group in South Palm Beach County. Excellent facilities. Compensation includes possibility of ownership in P.A. Send CV to P.O. Box 23606, Oakland Park, Florida 33334.

PHYSICIAN WANTED: Non-Clinical disability evaluation medical consultation for Social Security. Full-time 40-hour week. Knowledge of electrocardiographic interpretation desirable. Write or call G. M. Davis, Chief Medical Consultant, 3438 Lawton Road, Suite 127, Orlando, Florida 32803. Phone (305) 896-4691.

TWO MAN OFFICE ON ANNA MARIA ISLAND needs high quality Family Physicians. New building, fully equipped with lab and x-ray. Exceptional opportunity for ownership. Contact E.P. Dickerson, M.D., 2010 59th Street West, Bradenton, Florida 33505, or call collect (813) 792-2211.

PREPAID HEALTH CARE, INC., a Federally qualified HMO, is recruiting internists, BE or BC, for adult ambulatory care units in Clearwater and St. Petersburg. Excellent salary and benefit programs, with opportunity to participate in academic program available. Progressive, growing community. If interested in growing with us, send CV to Jerry Williamson, M.D., Medical Director, 1417 South Belcher Road, Clearwater, Florida 33516. Phone (813) 535-3474.

OCCUPATIONAL PHYSICIAN: Join us in caring for people who will launch America's Space Shuttle. Physicians needed at Pan American World Airways, Occupational Health Facility, Kennedy Space Center, Florida. Duties include physical exams, out-patient care and emergency medical services. Work a normal 40-hour week with seven other physicians with excellent nursing, laboratory and other technical capabilities. Benefits include reduced air travel. Submit resume to: N. M. Dunn, M.D., Pan Am 9, Kennedy Space Center, Florida 32899.

FEDERALLY QUALIFIED HMO IS RECRUITING Family Practitioners for ambulatory care facilities in Clearwater, Florida. Competitive salary and comprehensive benefit program with opportunity to participate in academic program available. If team interaction and casual living appeal to you, send CV to Jerry Williamson, M.D., 1417 S. Belcher Road, Clearwater, Florida 33516. Phone (813) 535-3474.

FAMILY PRACTITIONER, Moore Haven, Florida, on Lake Okeechobee, population 1,500. No doctor in county; excellent fishing and hunting. Industries include cattle, farming (sugar cane +), fishing. Call (813) 946-1212 between 9-5 p.m., Monday through Friday.

UNIVERSITY PHYSICIAN for Urban University with Medical/Nursing Schools, and excellent fringe benefits. Contact L. E. Stevens, M.D., Director, University of South Florida, Student Health Services, Tampa, Florida 33620. An Equal Opportunity Employer.

PHYSICIAN WANTED TO SHARE NEW FURNISHED OFFICE. Vacant two days each week. In Margate, a chance to see if area's for you. Individual consultation offices. Great for new practitioner. Inquire: C. Rodano, P.O. Box 242, Loxahatchee, Florida 33470.

INTERNIST WITH SPECIALTY TRAINING in Pulmonary or Cardiology to join three doctors in busy North Miami practice. Mail CV to Stanford B. Cooke, M.D., 12570 N.E. 7th Avenue, North Miami, Florida 33161.

WANTED: INTERNIST, Board eligible or certified, to join in association with two other established certified internists in Pompano Beach, Florida. Excellent office and laboratory facilities. Night call and office expenses are shared equally. Reply: Drs. Lewis — Schalk, Suite 104, 1800 North Federal Highway, Pompano Beach, Florida 33062.

SURGEON — GENERAL, Board Certified preferred, Thoracic and Vascular also preferred, to associate with an established Surgeon or have practice arrangement. Location small town suburb of Orlando. Write C-976, Post Office Box 2411, Jacksonville, Florida 32203.

PHYSICIAN FOR CORRECTIONAL INSTITUTION. Family Practice or Internal Medicine specialty preferred. 40 hour work week, good salary. Contact Melvin Gardner, Personnel Officer, Missouri State Penitentiary, 631 State Street, Jefferson City, Missouri 65101 or phone (314) 751-3224.

FAMILY PHYSICIAN GROUP in beautiful Boca Raton seeking qualified and motivated FP. Guarantee plus percentage with liberal benefits. The ocean, ideal weather, and an exploding population makes area particularly attractive. Send CV, or call James W. McCauley, M.D., 745 Meadows Road, Boca Raton, Florida 33432. (305) 392-0310.

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INTERNIST OR FAMILY PRACTITIONER to take over a well established Internal Medicine practice in Suncoast Florida. Excellent gross. Equipment and building with doctor tenants included in sale or lease to qualified applicant. Available July or August 1980. Reply C-975, Post Office Box 2411, Jacksonville, Florida 32203.

FAMILY PRACTICE PHYSICIAN (Bilingual) needed immediately to join as associate in French Canadian oriented practice in Hollywood, Florida. Must possess Florida license or have application pending and be board eligible or certified by the American Board of Family Practice. Will consider physician just out of Family Practice residency. Income guaranteed. Send CV to: Norman Wiesenthal, M.D., 4440 Sheridan Street, Hollywood, Florida 33021.

SURGERY DIRECTOR: Opening for Director of Residency Training Program in Surgery with Pensacola Educational Program, Pensacola, Florida, for Board Certified physician. Total program of 50 residents in six different residencies associated with four different hospitals in community-based educational program. Salary competitive with excellent fringe benefits of paid vacation, liability insurance, health and disability insurance, paid educational and professional trips. Program affiliation with several large medical schools. Gulf Coast living at its best, and health care in immediate area of over ¼ million. Must fill position by July 1, 1980. If interested in teaching and patient care, call collect: Dr. R. D. Nauman, Director of Medical Education, (904) 477-4956 or send CV to Director of Medical Education, Pensacola Educational Program, 5149 North Ninth Avenue, Suite #307, Pensacola, Florida 32504.

UNIVERSITY PHYSICIAN, UNIVERSITY OF FLORIDA must have completed one year of internship, as well as two years of residency in a recognized specialty, or four years of general practice. Also must be licensed in the state of Florida, be Board Certified or eligible in Family Practice, Internal Medicine, or Pediatrics. Experience in athletic medicine desired. Send complete resumes and salary requirements by June 5, 1980 to: Mr. Robert L. Willits, Assistant Personnel Director, Second Floor HUB, University of Florida, Gainesville, Florida 32611. Equal Employment Opportunity/Affirmative Action Employer. The University of Florida complies with Section 503 of the REHABILITATION ACT of 1973 and Section 402 of the VIETNAM ERA VETERANS READJUSTMENT ACT of 1974.

Situations Wanted

SITUATION WANTED: OB/GYN, 28, U.S. schooled and trained, seeks group or partnership position on East coast. Will consider all offers. Write C-943, P. O. Box 2411, Jacksonville, Florida 32203.

UROLOGIST, 31, married, Board eligible, excellently trained at major NYC University Medical Center, available June 1980; desires association, partnership, group or solo practice in Florida. Phone (212) 628-7354.

M.D.: AMERICAN TRAINED, board certified by the American Board of Obstetrics and Gynecology with a Florida license, 42, male, U.S. citizen, interested in buying, joining or associating with another M.D. in the specialty of OB-GYN, preferably on the eastern coast of Florida, population of not less than 40-60,000. Applicant has 10 years experience. For further information contact Mr. Soril at (516) 694-1164 after 7:30 p.m., or write: C-970, Post Office Box 2411, Jacksonville, Florida 32203.

INTERNIST-NEPHROLOGIST finishing nephrology fellowship in large N.Y.C. hospital, seeking to associate with established Internist. Any position considered. Strong clinical experience with the geriatric patient and a fluent command of both Spanish and English. Write or call for C.V. to Lawrence Bress, M.D., Coney Island Hospital, Brooklyn, N.Y. 11235 or phone 1-800-432-7999, ext. 381.

RADIOLOGIST, 30 YEARS CLINICAL PRACTICE in South Florida, completing one year post-doctoral fellowship in abdominal ultrasound and CT imaging, in July 1980 at Johns Hopkins Hospital. Desire salaried position in general hospital including obstetrics in ultrasound and CT scanning in South Florida. Reply to Maurice M. Greenfield, M.D., Department of Radiology and Radiological Science, The Johns Hopkins Hospital, Baltimore, Maryland 21205, or call (301) 955-5811.

OB/GYN — 29-year-old American male, Emory University/Grady trained M.D. wishes to join group practice in coastal Florida. Licensure by reciprocity. Write N. B., 3860 Bretton Woods Road, Decatur, Georgia 30030. Available July 1981.

INTERNIST / HEMATOLOGIST / ONCOLOGIST, 32, ABIM, eligible Hematology-Oncology boards, seeks solo or group practice or practice for sale. Available July 1980. Resident, 4633 Alter Road, Detroit, Michigan 48215.

UROLOGIST, 30, married, American, board eligible, chief resident Georgetown University Hospital, Washington, D.C., available July 1980, seeks partnership or group practice; prefers Southeast Florida, but all areas considered. Florida licensed. Call (703) 528-4036 after 6 p.m.

GENERAL SURGEON, Board Certified, F.A.C.S., F.R.C.S.(C.), 20 years surgery, trauma and industrial practice wishes relocation in 1981 to Florida Gulf Coast. Write all offers to C-973, Post Office Box 2411, Jacksonville, Florida 32203.

PEDIATRICIAN, Board Certified, wishes to buy practice or join solo or Association in Miami — West Palm Beach area. Write C-974, Post Office Box 2411, Jacksonville, Florida 32203.

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Classified advertising rates are $10.00 for the first 25 words or less and 25 cents for each additional word. Deadline is first of the month preceding month of publication.

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- Action at urinary/vaginal/lower bowel sites helps eliminate reservoirs of infecting organisms
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Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* **It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination.** *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register*, 37:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older.

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

Pneumocystis carinii pneumonitis: Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets,* each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. *Tablets,* each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. *Oral suspension,* containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

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the Bactrim™ 3-system counterattack



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Bactrim has shown high clinical effectiveness in recurrent cystitis as a result of its wide spectrum and distinctive antimicrobial action in the urinary, vaginal and lower intestinal tracts.

The probability of recurrent urinary tract infection appears to be enhanced by the establishment of large numbers of *E. coli* or other urinary pathogens on the vaginal introitus. The trimethoprim component of Bactrim diffuses into vaginal fluid in effective concentrations, thus combating migration of pathogens into the urethra.

Studies have shown that Bactrim acts against *Enter bacteriaceae* in the bowel without the emergence of re tant organisms. Thus, Bactrim reduces the risk of intr colonization by fecal uropathogens. It has *no* signifi- cant effect on other normal, necessary intestinal flora

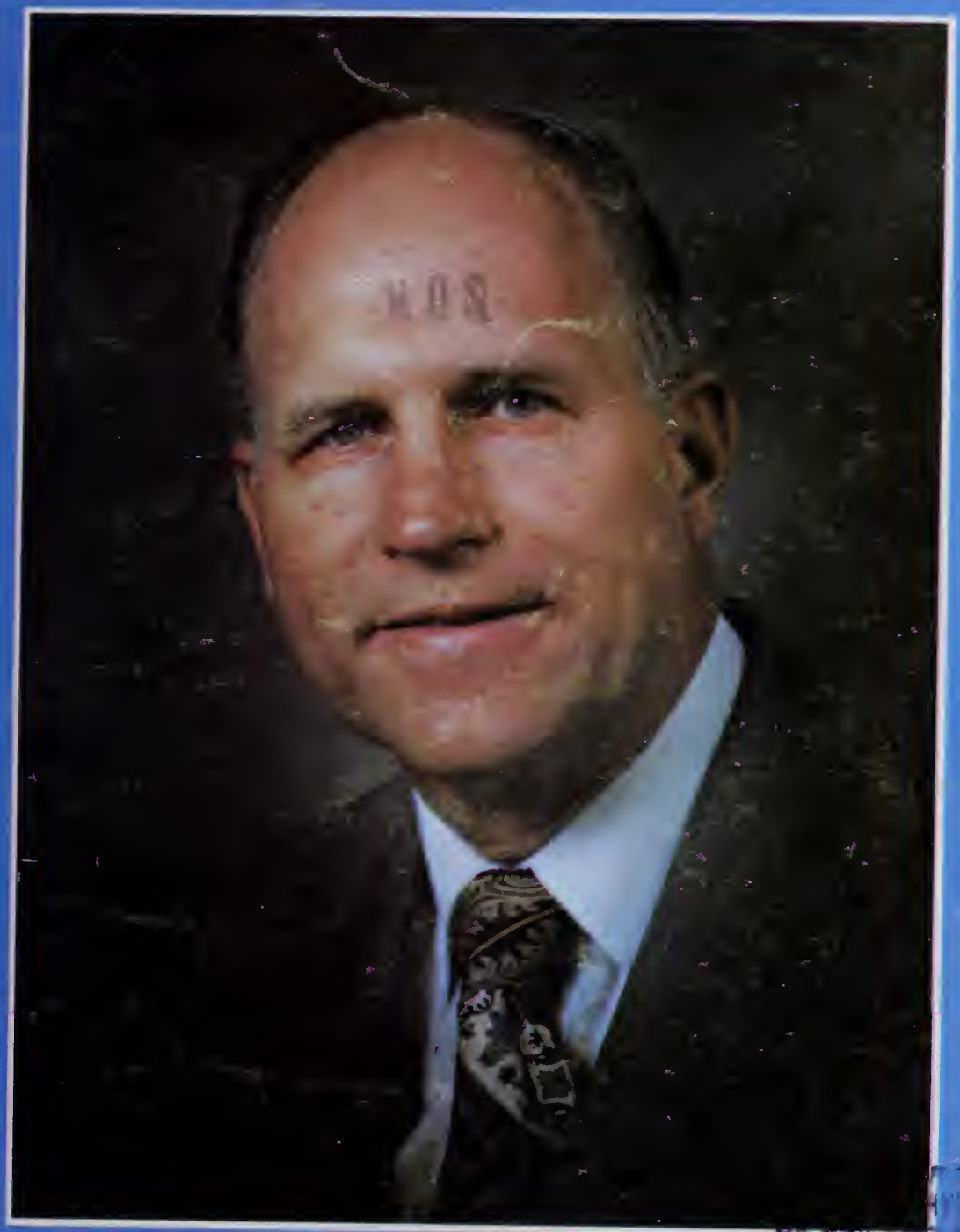
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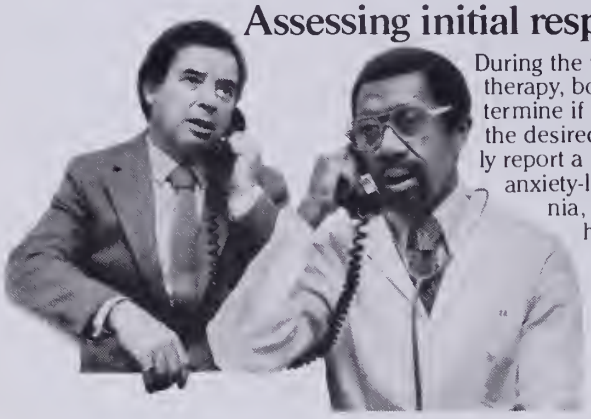


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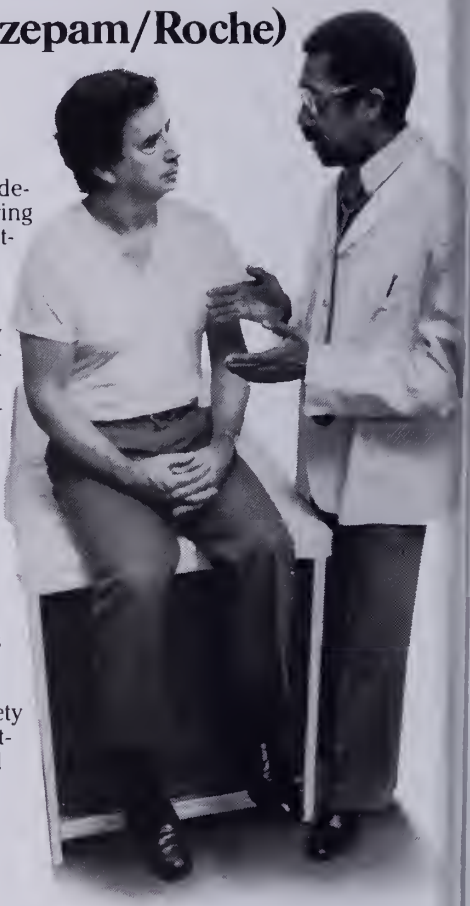
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Monitoring patient response to Valium® (diazepam/Roche)

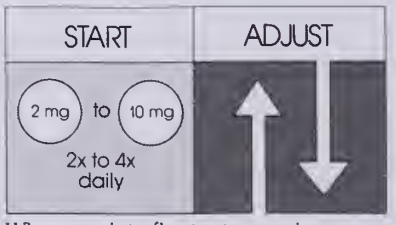


Assessing initial response to therapy

During the first follow-up visit after initiating therapy, both physician and patient should determine if Valium (diazepam/Roche) is having the desired effect. Most patients will promptly report a feeling of relaxation and relief of anxiety-linked symptoms such as insomnia, headaches, palpitations and hyperventilation. You will probably observe that the patient is calmer and more relaxed. If, however, patient response does not measure up to expectations, a reevaluation of the patient's profile with modification of the dosage regimen should be considered.



Making dosage adjustments



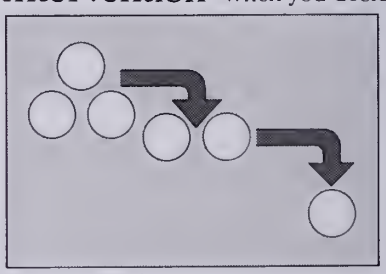
With any psychoactive medication it is good medical practice to initiate therapy at base dosage levels and titrate to the patient's needs. With Valium, experience has shown that 5 mg t.i.d. is usually sufficient although some patients with severe or persistent anxiety may require higher dosages initially. In geriatric or debilitated patients, the recommended dosage is 2 to 2½ mg once or twice daily. When anxiety fluctuates, as is common with most patients, the dosage may be adjusted as needed during the course of therapy; three strengths in scored tablets give you unmatched flexibility and simplicity in individualizing dosage.

Evaluating progress toward therapeutic goals

SET GOALS						
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

At the beginning of therapy it is now common practice for both physician and patient to establish treatment goals and to estimate the amount of time needed to achieve them. Then the patient knows what to expect and when to expect it. Some physicians find that compiling a checklist of presenting symptoms and complaints is useful for assessing the patient's response from visit to visit. In this way, progress toward attainment of the therapeutic goal is reviewed at regular intervals. As patients feel their symptoms abate and begin to develop insight into the sources of their anxiety and psychic tension, the checklist can be expected to dwindle.

Discontinuing pharmacologic intervention



When you decide to discontinue therapy, tapering dosa is good medical pract Although rarely nec- essary after short-tern treatment with Valiun gradual dosage reduc is advisable for patier who have been on ex tended therapy. This ı ual discontinuance should preclude eith recurrence of pretreatment symptoms or development of u toward side effects. Symptoms of withdrawal have almost ways been associated with abrupt discontinuance of thera higher dosages taken continuously over long periods of tin

2-mg, 5-mg, 10-mg scored tablets

Valium® (IV) diazepam/Roche

An Important Adjunct to Your Treatment Program for Excessive Anxiety

ROCHE®

See the following page for a summary of product information.

Valium® (diazepam/Roche) ℞

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety associated with anxiety disorders, transient situational disturbances and functional or organic disorders, psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal, adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).
The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

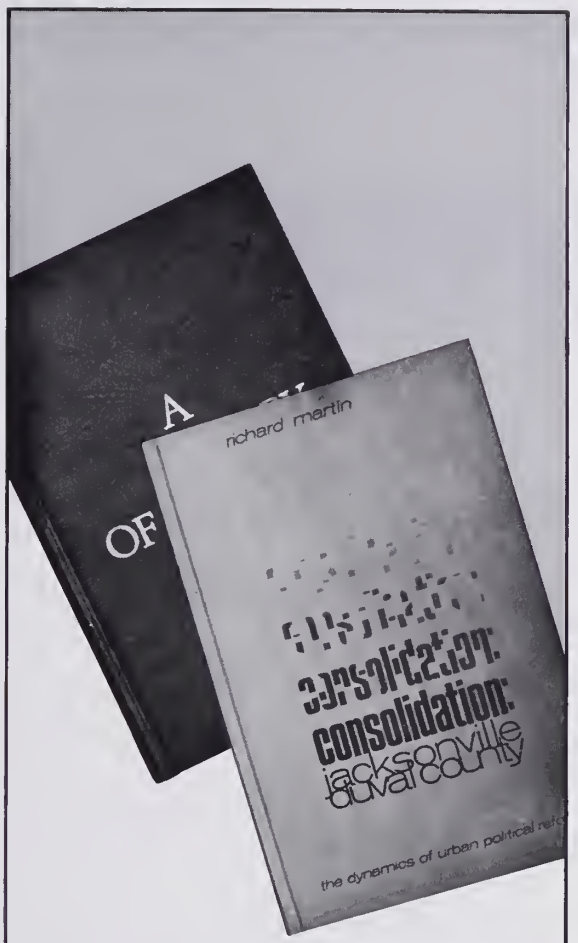
Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults*: Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients*: 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children*: 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® Tablets, 2 mg, 5 mg and 10 mg—bottles of 100 and 500, Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10. Prescription Paks of 50, available in trays of 10.

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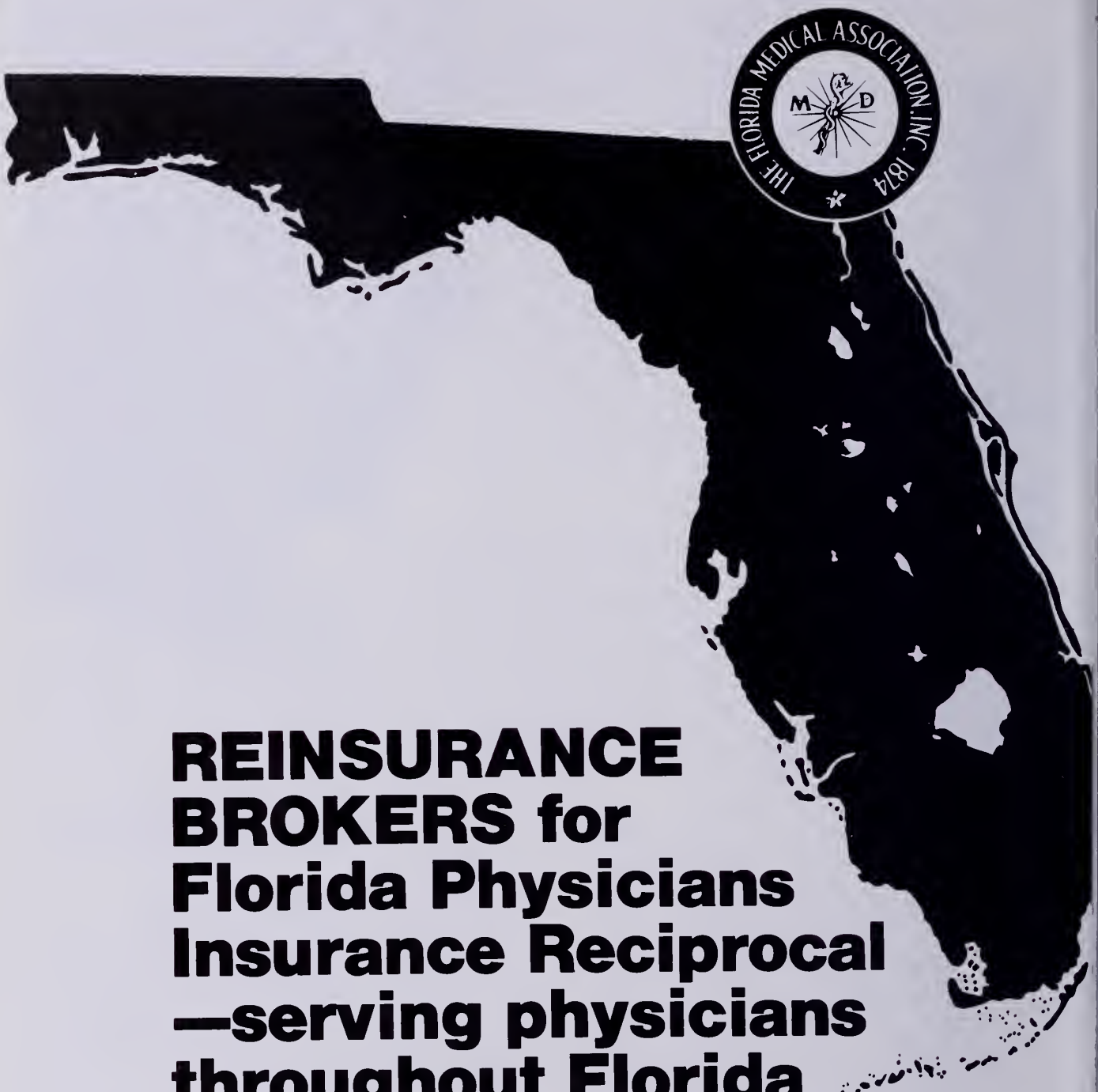
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On the Cover

Thomas B. Thames, M.D., 104th President of the Florida Medical Association.

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President's Page

On Becoming President

I am pleased to have this first opportunity to write to you since assuming the office of President of this fine organization at the Annual Meeting in Hollywood, Florida, May 7-11, 1980. I am proud to assume this position and pledge to continue the efforts on your behalf to ensure quality health care for Florida citizens under a health care system with the least possible government interference. I look forward to continuing to work with the other elected officers chosen to serve and your exceptional FMA staff.

The FMA House of Delegates took an extremely important action at its meeting in approving the report and recommendations of the Special Committee of the Board on Finance, which authorizes your Board of Governors to examine the entire FMA Council and Committee structure, their functions, staffing, costs of operation and the effectiveness and value of their activities to FMA members as well as from a public relations standpoint. I hope that each of you will take the time to review this important report carefully, which will be included in the Official Proceedings of the House of Delegates in the July issue of *The Journal.*

The House action gives the Board both the opportunity and responsibility for reassessing the Association's goals and objectives in the face of a continuing inflationary economy and the increasingly challenging issues facing medicine, and to reorganize and/or adapt the FMA's organizational structure and activities in such a way as to insure the Association's ability to continue to serve the membership and the public in the most effective way at the most reasonable financial cost. To aid in accomplishing this goal, a Committee of the Board has been appointed and charged with the responsibility of developing a proposed reorganization plan for presentation to the Board of Governors for consideration at its June meeting.

Undoubtedly, stability of the professional liability insurance market in Florida is an issue of grave concern to all of us and as I write this article, I cannot predict the fate of our Recovery of Costs legislative proposal currently under consideration by the Florida Legislature in Tallahassee. I can assure you, however, that your previous and present leaders have, and will continue to do their utmost on your behalf through the news media, key contact physicians, our Tallahassee, Headquarters and field office staffs, Auxiliary and patient contacts to enable us to enact this legislation. Without its passage, staggering increases in the cost of professional liability insurance are imminent and pose a real threat of forcing many of us to go "bare" or pass on these costs to our patients, further fueling the spiral of inflationary costs.

I know each member of your Board of Governors personally, as I do our dedicated professional staff, and I am personally acquainted with most every Council and Committee Chairman. We have a truly dedicated group who will work to their utmost to provide leadership of which you can be proud. However, all of us know that we cannot be successful without the help of each of you — individually and collectively. Please assist us on your own behalf and that of your fellow physicians. Urge your spouses to join the Auxiliary and help them help us with our programs. Encourage your friends who do not belong to their county society or FMA to reconsider uniting with us to prevent further government encroachment on our freedom to practice medicine. Continue to be active politically through FLAMPAC, as well as personal donations of time and money to the candidates of your choice. Your country needs your help, the FMA needs your help, I need your help for the coming year to be successful for all of us.

Thomas B. Thames, M.D.

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Editorial

A New Beginning

"At the forty-first annual meeting of the Florida Medical Association, held in Orlando last May, it was decided to publish monthly a State medical journal....The main object in launching this publication is to stimulate the interest of the profession in the State in organized medicine in general and the State society in particular."

Graham E. Henson, M.D., (Editor), *The Journal of the Florida Medical Association*, Vol. 1, No. 1 (July 18, 1914).

Publication of the June issue signals **a new beginning** in the historical annals of *The JFMA*. With the retirement of Gerold L. Schiebler, M.D., as Editor, a changing of the guard will have taken place for the ninth time since *The Journal's* incipience. As the newly appointed Editor, I am deeply grateful to President Thames and the Board of Governors for their confidence and support in bestowing this honor upon me. In beginning anew, I wish to pledge my utmost enthusiasm and dedication to uphold the high standards of *The Journal* established by my predecessors.

As with all things, change is inevitable. Rien au monde ne dure, qu' un eternal changement (Nothing in the world lasts save eternal change).[1] Consequently *The JFMA* must not remain at a standstill, but should continually progress. To once again quote the first Editor,[2] "Because we now publish a good journal is no reason why we should not publish a better one." With these thoughts in mind, the new editorial staff will diligently strive to improve the overall quality of *The Journal*, an important part of which includes providing the most worthwhile information with the least expenditure of time to readers. In order to achieve this aim, as well as our ultimate goal, the best state medical journal in the country, we need the wholehearted support of the entire FMA membership. Certainly, the FMA is gifted with numbers of first class physicians capable of making significant contributions to *The Journal*. Along these lines, I would also remind you that, "no physician knows all medicine and sometimes the most exalted may obtain a bit of knowledge from the most humble."[3]

Daniel B. Nunn, M.D.

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1. Honorat de Bueil, Marquis de Racan: Odes the Coming of Spring.
2. Graham E. Henson, M.D.: JFMA, Vol. 1, No. 2, 1914.
3. Ibid.

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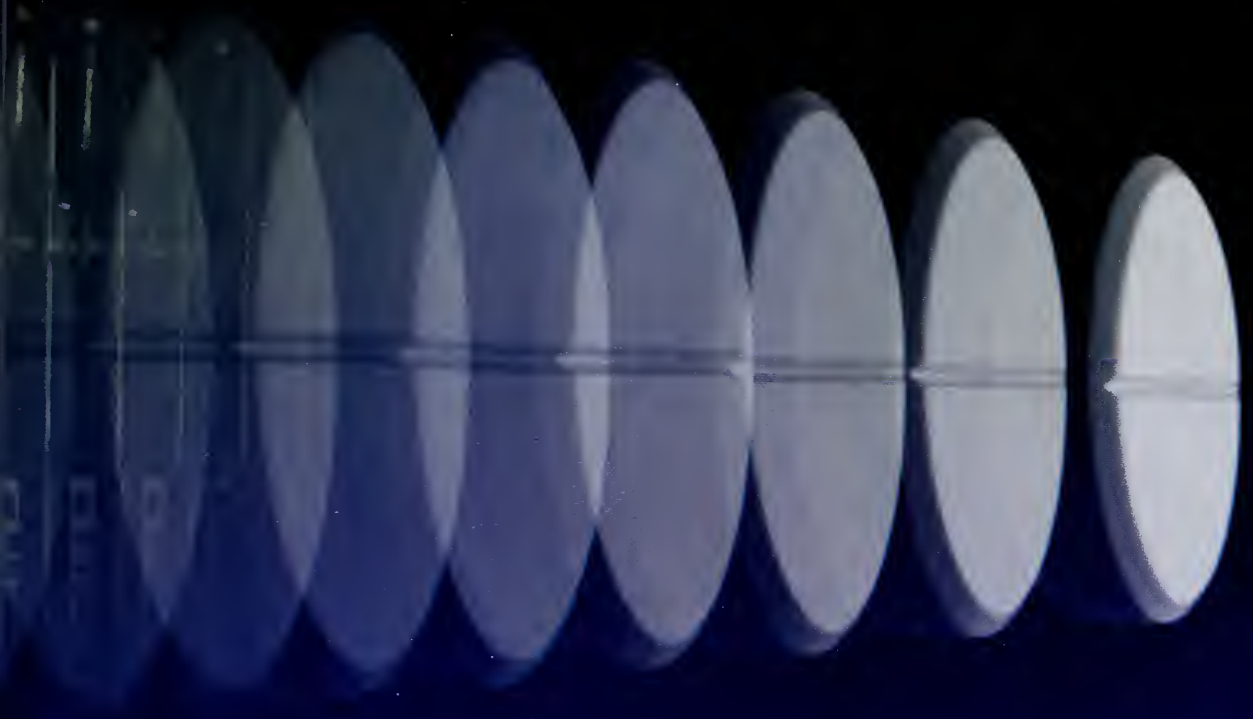
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Warnings: Excessive theophylline doses may be associated with toxicity; serum theophylline levels should be monitored to assure maximum benefit with minimum risk. Incidence of toxicity increases at serum levels greater than 20 mcg/ml. High blood levels of theophylline resulting from conventional doses are correlated with clinical manifestations of toxicity in: patients with lowered body plasma clearances, patients with liver dysfunction or chronic obstructive lung disease, and patients who are older than 55 years of age, particularly males. There are often no early signs of less serious theophylline toxicity such as nausea and restlessness, which may appear in up to 50% of patients prior to onset of convulsions. Ventricular arrhythmias or seizures may be the first signs of toxicity.

Many patients who have higher theophylline serum levels exhibit a tachycardia. Theophylline products may worsen pre-existing arrhythmias.

Usage in Pregnancy: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development, but neither have adverse effects on fetal development been established. This is, unfortunately, true for most anti-asthmatic medications. Therefore, use of theophylline in pregnant women should be balanced against the risk of uncontrolled asthma.

Precautions: THEO-DUR TABLETS SHOULD NOT BE CHEWED OR CRUSHED. Theophyllines should not be administered concurrently with other xanthine medications. It should be used with caution in patients with severe cardiac disease, severe hypoxemia, hypertension, hyperthyroidism, acute myocardial injury, cor pulmonale, congestive heart failure, liver disease and in the elderly, particularly males, and in neonates. Great caution should be used in giving theophylline to patients in congestive heart failure since these patients show markedly prolonged theophylline blood level curves. Use theophylline cautiously in patients with history of peptic ulcer. Theophylline may occasionally act as a local irritant to G.I. tract although gastrointestinal symptoms are more commonly central and associated with high serum concentrations above 20 mcg/ml.

Adverse Reactions: The most consistent adverse reactions are usually due to overdose and are:

Gastrointestinal: Nausea, vomiting, epigastric pain, hematemesis, diarrhea.

Central Nervous System: Headaches, irritability, restlessness, insomnia, reflex hyperexcitability, muscle twitching, clonic and tonic generalized convulsions.

Cardiovascular: Palpitation, tachycardia, extrasystoles, flushing, hypotension, circulatory failure, life threatening ventricular arrhythmias.

Respiratory: Tachypnea.

Renal: Albuminuria, increased excretion of renal tubular cells and red blood cells; potentiation of diuresis.

Others: Hyperglycemia and inappropriate ADH syndrome.

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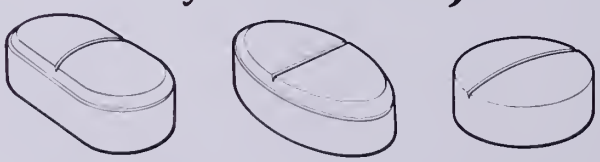
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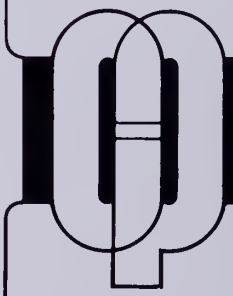


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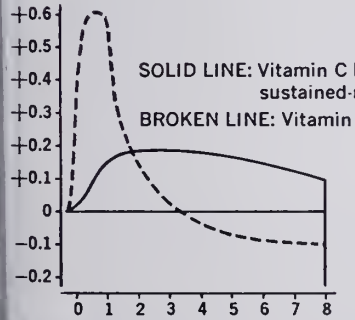
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1. Riccitelli, M.L.: Vitamin C Therapy in Geriatric Practice, J. Amer. Geriatrics Soc. 20:34, 1972.
2. Riccitelli, M.L.: Vitamin C—A Review. Conn. Med. 39:609, 1975

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FROM THE EDITOR'S DESK

PHYSICIAN FEES WELL BELOW CPI

AMA Board of Trustees Chairman Lowell H. Steen, M.D., testified before the Price Advisory Committee of the Council on Wage and Price Stability that the AMA's call for voluntary fee restraint has resulted in fee increases that are far behind the rate of inflation in the general economy. Dr. Steen reported that in 1978 the all-items category of the Consumer Price Index rose 9.0% and physicians fees rose 8.1%. In 1979, the CPI went up 13.3%, while physicians' fees were rising 9.4%.

HOSPITALS ESSENTIALLY HELD COSTS DOWN IN 1979

The American Hospital Association reports that hospitals essentially achieved their goal of holding down the rate of increase in costs during 1979. Total expenses increased 13.4% last year. After adjustment for double-digit inflation, the rate of increase fell to 11.7%. The 1979 goal, which was set two years ago, called for a rate of increase of 11.6%. Hospital admissions rose last year 2.7% compared to an increase of 0.4% in 1978. The figures were presented by AHA to the National Steering Committee of the Voluntary Effort to Contain Hospital Costs.

IOWA CHIROPRACTORS CLAIM CONSPIRACY

The Health Care Equilization Committee of the Iowa Chiropractic Society filed charges last year in Des Moines claiming that the AMA, the Iowa Medical Society and other organizations and individuals conspired to refuse to deal with chiropractors and to monopolize health care. The AMA was scheduled to present arguments in the case in late April.

SUPREME COURT RULING LIMITS PRIVACY

The Supreme Court decision upholding the right of police to search the files of a Stanford University newspaper for photographs of a campus episode at which a crime occurred has opened the way for "abusive invasions that occur by law enforcement officials into the security and privacy of physicians' offices," according to the AMA and the American Psychiatric Association. The charges were made to the Senate Judiciary Committee by AMA and APA representative Nancy Roeske, M.D., of Indianapolis. Dr. Roeske added that the search procedure by police, as contrasted to the subpoena request "is particularly pernicious since it does not allow the physician to challenge the disclosure of his records on grounds that they are both privileged and confidential."

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Borrowed Servant Doctrine

This case involved allegedly negligent post-operative care rendered to a four month old patient by Variety Children's Hospital's residents and nurses. The infant patient had been admitted to Variety by a private pediatric and thoracic surgeon for a tracheotomy to correct a congenital condition in the infant's windpipe. Following uneventful surgery, and after examining the patient in the intensive care unit and giving instructions as to his treatment, the doctor left the hospital. The child then came within the "exclusive care" of the nurses and residents employed by the hospital. Following a series of events concerning the infant's condition, he became cyanotic and stopped breathing for a five to seven minute period during which he sustained irreversible brain damage. The cause of this medical catastrophe was a massive pneumothorax. There was ample expert testimony that both the nurses and residents had been negligent in failing to employ adequate medical procedures in the light of the symptoms which the infant had exhibited for almost two hours before the crisis occurred, and in the resuscitation efforts employed after its onset.

In this appeal, Variety urged that the trial court had committed error in ruling that (1) the hospital was vicariously liable as a matter of law for the conduct of its residents and (2) in therefore denying the hospital's requested instruction which would have permitted the jury to find that the residents were the "borrowed servants" of the offending physician so that he, rather than Variety was responsible for their negligence. The appellate court rejected Variety's arguments noting that the record contains no evidence whatever on which the jury could properly have found that Variety's residents, who were employed and paid by the hospital and were under its supervision and control, became "borrowed servants" of the physician at the time of the commission of their negligent acts. A hospital is, as a general rule, liable for the negligence of interns or residents like those involved in this case. The court recognized that such an employee may in some instances come under the direction and control of an attending physician so as to shift responsibility for his acts from the hospital to the doctor. The court reasoned, however, this principle has utterly no application to the case at bar, because the negligence occurred when the surgery had long since been completed and the surgeon was neither physically present nor any longer directing the activities of the hospital employees. The court felt that it was fundamental that the "respondeat superior doctrine" applies only when the alleged master has the ability and authority to direct and control the pertinent acts of the employee. Based upon this doctrine, the courts have unanimously held that in a post-surgical situation such as the one in this case, the hospital and not the physician is liable for the acts of the employees. In affirming the lower court's decision, the appellate court held "a contrary holding, accepting Variety's position on the facts of this case, would both expose every admitting physician to liability for the actions of hospital employees merely because he remains generally in charge of the patient's care; and simultaneously relieve the hospital of responsibility for services which it alone should provide and for which it is paid."

Prepared and submitted by John E. Thrasher, J.D., Vice President and Legal Counsel, and Anthony J. McNicholas III, J.D., Associate Legal Counsel, Professional Insurance Management Co. (PIMCO), Jacksonville, Florida.

Being right half of the time beats being half right all of the time.

Malcolm Forbes

Dean's Page

A Valediction

The Florida Medical Association has been very gracious for permitting me to contribute to *The Journal* for the past three years. Since I shall be leaving my current position and joining the staff of the American Medical Association in July, this is my last Dean's Page.

As an Association of professional colleagues, you have been most supportive of medical education in this state. The spirit of cooperation, mutual respect, and frequent dialogue, have brought the practice of medicine and the education of physicians to a unique synergism. Our mutual ultimate goal is to provide the highest quality of medical care to our patients.

The provision of medical care is a continuum beginning with the education of young men and women in pre-medical education. Following a comprehensive screening process, the formal aspect of medical education begins. Specialty training follows. The delivery of medical care by both faculty members and private practitioners unites us. Continuing education is another common bond. Research activities of faculty members benefit all because today's basic science is tomorrow's clinical science. So, in every respect, our mission is common.

Medical education in this state and, indeed, the nation, needs your support now, more than ever. Each of us must do our part to assure the state and nation of continuing high quality medical care.

Medical education is *your* education, a life long process.

Dr. Deal is Vice President for Health Affairs and Dean, University of Florida College of Medicine, Gainesville.

● Dr. Deal, University of Florida College of Medicine, Gainesville, Florida 32610.

The opinions stated on this page are those of the individual Deans and do not necessarily represent the policy of the FMA.

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DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberel cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be releted to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligosperma and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg. Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D., I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only

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Summary of the FMA Board of Governors Meeting May 11, 1980

The Board of Governors held an organizational meeting immediately following the conclusion of the FMA Annual Meeting at the Diplomat Hotel in Hollywood, Florida, on Sunday, May 11, 1980. The following is a summary of the actions taken by the Board.

FMA Board of Governors and Executive Committee Composition

The Board approved the President's nominations for appointment of advisory members to the Board. Vernon B. Astler, M.D., Florida Physicians' Insurance Reciprocal Representative and Public Relations Officer; Eugene G. Peek, Jr., M.D., HRS Representative; Benjamin M. Cole, M.D., State Board of Medical Examiners Representative

J. Lee Dockery, M.D., was appointed as the optional member of the FMA Executive Committee.

The newly constituted Board of Governors for the coming year will be as follows:

*T. Byron Thames, M.D., President
*Sanford A. Mullen, M.D., President Elect
*Gerold L. Schiebler, M.D., Vice President
*Robert E. Windom, M.D., Secretary
*J. Russell Forlaw, M.D., Treasurer
*Richard S. Hodes, M.D., Immediate Past President (82)
O. William Davenport, M.D., Past President (81)
**J. Lee Dockery, M.D., District A (82)
Thomas E. McKell, M.D., District B (83)
James G. White, M.D., District C (81)
Norman M. Kenyon, M.D., District D (84)
James F. Richards, Jr., M.D., At Large (81)
Joseph C. Von Thron, M.D., AMA Delegate (81)
James B. Perry, M.D., Speaker of the House
Vernon B. Astler, M.D., FPIR, Public Relations Officer (81)
Benjamin M. Cole, M.D., SBME (81)
Eugene G. Peek, Jr., M.D., HRS (81)

*Executive Committee
**Optional Member of the Executive Committee

FMA Journal Representative

J. Lee Dockery, M.D., was appointed as Assistant Editor of the FMA Journal from the Board of Governors.

FMA Councils and Committees and Board Committees

The House of Delegates approved a report of the Special Committee on Finance of the Association which will involve reorganization of the Association's structure.

In view of this action, all Council and Committee appointments will remain the same until the reorganization is completed in June with the exception of the Council on Legislation. Louis C. Murray, M.D., was appointed Chairman of the Council on Legislation and Francis C. Coleman, M.D., appointed Vice Chairman of the Council and Chairman of the Committee on National Legislation.

Pursuant to the House action in approving the report and recommendations of the Special Committee on Finance and the report of the Board of Governors regarding the position of the Executive Vice President following Dr. Parham's retirement in 1984, the Board approved the appointment of a Board Committee on Finance, as well as, a Board Committee on Management:

Board Committee on Finance

J. Russell Forlaw, M.D., Chairman
T. Byron Thames, M.D.
Robert E. Windom, M.D.

Board Committee on Management

Vernon B. Astler, M.D., Chairman
James B. Perry, M.D.
T. Byron Thames, M.D.

The Board approved the President's nominations for the Directors of the Florida Medical Foundation.

Eugene G. Peek, Jr., M.D.
T. Byron Thames, M.D.
Norman M. Kenyon, M.D.
J. Lee Dockery, M.D.
W. Harold Parham, D.H.A.

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ibuprofen



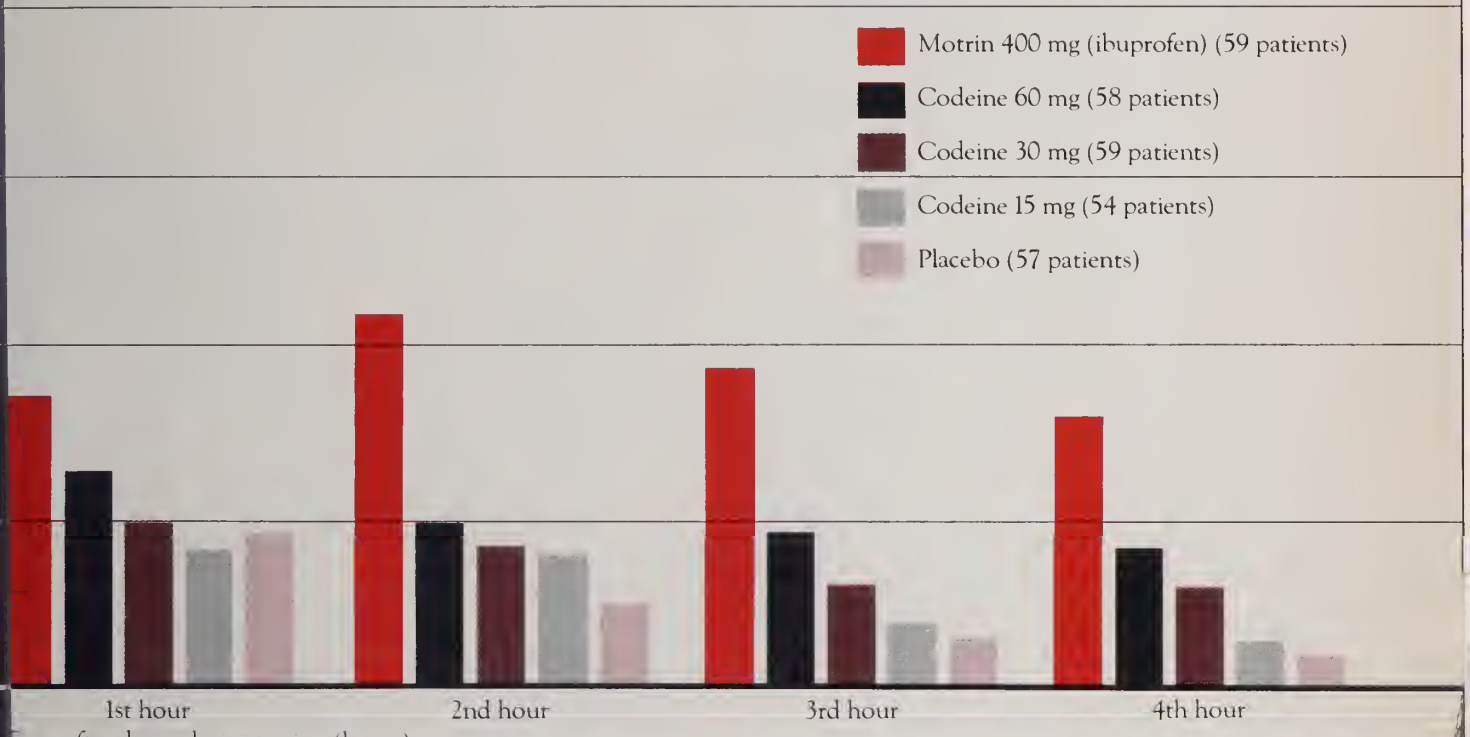
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ase turn the page for a brief summary of prescribing information.

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Motrin® (ibuprofen) now proved an effective analgesic for mild to moderate pain

Motrin® Tablets (ibuprofen, Upjohn)

Indications and Usage: Relief of mild to moderate pain.

Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in long-term management. Safety and efficacy have not been established in Functional Class IV rheumatoid arthritis.

Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS).

Warnings: Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

Drug interactions. *Aspirin* used concomitantly may decrease Motrin blood levels. *Coumarin:* Bleeding has been reported in patients taking Motrin and coumarin.

Pregnancy and nursing mothers: Motrin should not be taken during pregnancy or by nursing mothers.

Adverse Reactions

Incidence greater than 1%

Gastrointestinal: The most frequent type of adverse reaction occurring with Motrin is gastrointestinal (4% to 16%). This includes nausea,* epigastric pain,* heartburn,* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness,* headache, nervousness. **Dermatologic:** Rash* (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

*Incidence 3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

Dosage and Administration: Rheumatoid arthritis and osteoarthritis, including flares of chronic disease: Suggested dosage is 300, 400 or 600 mg t.i.d. or q.i.d. Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for relief of pain.

Do not exceed 2400 mg per day.

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May 1980

MEDICAL MESSAGE
from the Florida Doctors

THE FLORIDA MEDICAL ASSOCIATION, INC. 1894

FOODBORNE ILLNESS

Food poisoning is a little thought of disease of undefined magnitude on a worldwide basis. It occurs from the ingestion of contaminated food or beverage.

In the United States foodborne poisoning is a reportable disease so some statistical information is available. Clearly underreported, figures released for 1976 reveal 438 outbreaks of food or waterborne illness involving 12,463 people. A specific cause was established in only about one-third of those outbreaks.

There is no known way to guard against the possibility of contacting food poisoning. However, a number of general observations have been found to be helpful. Numerous cases have been reported involving hunters or campers who prepare perishable food in sandwich form prior to their trips and allow it to remain unrefrigerated too long before being eaten. The same is true in the home with some highly spiced cooked foods such as baked beans.

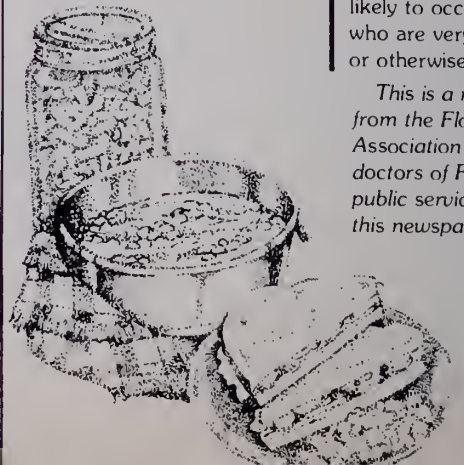
The more serious side of food poisoning is botulism. Home-preserved foods are most dangerous for this germ is a spore bearer, hence is not killed rapidly at boiling temperature. Reliable commercial packing houses sterilize their products at 248°F, which kills the spores. Often preserved food in which this germ has been growing looks soft and contains gas bubbles.

Since this toxin is destroyed rapidly by heat (within a few seconds at temperatures over 180°F) foods that might contain it, should be discarded.

In most cases, food poisoning may be either of an infectious or toxic origin. Diagnosis is usually approached by establishing the probable time lapse from ingestion to the onset of symptoms. Most cases of food poisoning and infectious gasteroentertis develop in a matter of hours after eating. The symptoms of botulism begin in from four hours to six days but usually in from 18 to 36 hours after ingestion of the contaminated food.

The rapidly apparent symptoms of foodborne poisoning are fever, headaches, nausea, vomiting, prostration, cramps and diarrhea. Upon suffering such symptoms, a physician should be contacted immediately.

Mortality due to food transmitted illness is most likely to occur among those who are very young or old or otherwise debilitated.



This is a medical message from the Florida Medical Association in behalf of the doctors of Florida and as a public service feature of this newspaper.



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Ventricular hypertrophy	Hepatic disease
Hyperglycemia	Hyperuricemia
Diabetes mellitus	Gouty arthritis
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Like any antihypertensive, use with caution in severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

work/play—normal hemodynamic responses to exercise maintained.

love—low incidence of impotence and/or loss of libido: 2.8% in 1,923 patients studied.[1]

cardiac output—tends to return to control values during long-term therapy.

blood flow—preserved in kidney.

No Single Advantage Determines Drug Choice.

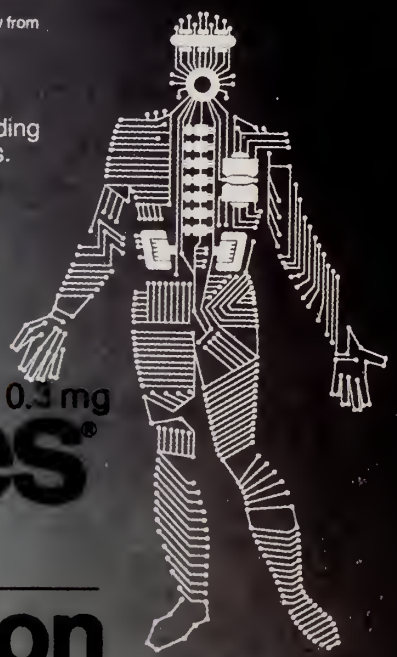
Other factors must include:

The drug's effectiveness in a given patient, its side effects, warnings, precautions, tolerance, etc. A rational therapeutic choice depends on a careful assessment of all such factors.

*Central alpha-adrenergic stimulation decreases sympathetic outflow from the brain, as shown in animal studies.

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Please see last page for brief summary, including warnings, precautions, and adverse reactions.



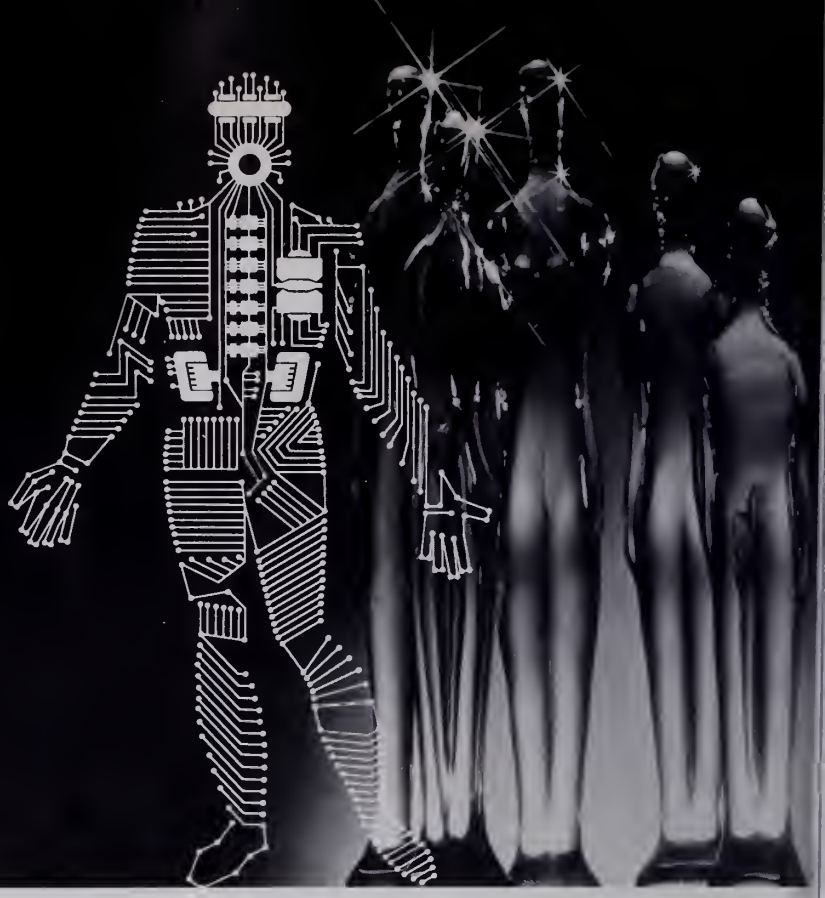
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Hypertension

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It's for all kinds of hypertensives



Tablets of 0.1, 0.2, 0.3 mg

Catapres®
(clonidine HCl)
Hypertension

- No contraindications.
- Effective in all degrees of hypertension. It is mild to moderate in potency.
- Low incidence of depression, impotence, orthostatic hypotension—no fatal hepatotoxicity.
- Preserves kidney blood flow.

Most common side effects are dry mouth, drowsiness, and sedation which generally tend to diminish with time.

The usual starting dose of Catapres is 0.1 mg at brea fast and 0.1 mg at bedtime. Some patients may bene from a starting dose of 0.1 mg at bedtime.

Usual daily dose range—0.2—0.8 mg

Maximum daily dose—2.4 mg
Doses as high as this have rarely been employed.

For optimal results, the dose of Catapres must be adjusted according to the patient's individual blood pressure response.

Catapres®
(clonidine hydrochloride)
Tablets of 0.1, 0.2, 0.3 mg

Indication: The drug is indicated in the treatment of hypertension. As an antihypertensive drug, Catapres (clonidine hydrochloride) is mild to moderate in potency. It may be employed in a general treatment program with a diuretic and/or other antihypertensive agents as needed for proper patient response.

Warnings: Tolerance may develop in some patients necessitating a reevaluation of therapy.
Usage in Pregnancy: In view of embryotoxic findings in animals, and since information on possible adverse effects in pregnant women is limited to uncontrolled clinical data, the drug is not recommended in women who are or may become pregnant unless the potential benefits outweigh the potential risk to mother and fetus.
Usage in Children: No clinical experience is available with the use of Catapres (clonidine hydrochloride) in children.

Precautions: When discontinuing Catapres (clonidine hydrochloride), reduce the dose gradually over 2 to 4 days to avoid a possible rapid rise in blood pressure and associated subjective symptoms such as nervousness, agitation, and headache. Patients should be instructed not to discontinue therapy without consulting their physician. Rare instances of hypertensive encephalopathy and death have been recorded after cessation of clonidine hydrochloride therapy. A causal relationship has not been established in these cases. It has been demonstrated that an excessive rise in blood pressure, should it occur, can be reversed by resumption of clonidine hydrochloride therapy or by intravenous phentolamine. Patients who engage in potentially hazardous activities, such as operating machinery or driving, should be advised of the sedative effect. This drug may enhance the CNS-depressive effects of alcohol, barbiturates and other sedatives. Like any other agent lowering blood pressure, clonidine hydrochloride should be used with caution in patients with severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

As an integral part of their overall long-term care, patients treated with Catapres (clonidine hydrochloride) should receive periodic eye examinations. While, except for some dryness of the eyes, no drug-related abnormal ophthalmologic findings have been recorded with Catapres (clonidine hydrochloride), in several studies the drug produced a dose-dependent increase in the incidence and severity of spontaneously occurring retinal degeneration in albino rats treated for 6 mo longer.

Adverse Reactions: The most common reactions are dry mouth, drowsine sedation. Constipation, dizziness, headache, and fatigue have been re Generally these effects tend to diminish with continued therapy. The fo reactions have been associated with the drug, some of them rarely. (Ir instances an exact causal relationship has not been established.) These i Anorexia, malaise, nausea, vomiting, parotid pain, mild transient abnorma liver function tests; one report of possible drug-induced hepatitis without and hyperbilirubinemia in a patient receiving clonidine hydrochloride. thalidone and papaverine hydrochloride. Weight gain, transient elevation c glucose, or serum creatine phosphokinase: congestive heart failure, Ra phenomenon; vivid dreams or nightmares, insomnia, other behavioral ch nervousness, restlessness, anxiety and mental depression. Also ra gioneurotic edema, hives, urticaria, thinning of the hair, pruritus not ass with a rash, impotence, urinary retention, increased sensitivity to alcohol, c itching or burning of the eyes, dryness of the nasal mucosa, pallor, gynecc weakly positive Coombs' test, asymptomatic electrocardiographic abnor manifested as Wenckebach period or ventricular trigeminy.

Overdosage: Profound hypotension, weakness, somnolence, diminishe sent reflexes and vomiting followed the accidental ingestion of Catapres (c hydrochloride) by several children from 19 months to 5 years of age. lavage and administration of an analeptic and vasopressor led to comp covery within 24 hours. Tolazoline in intravenous doses of 10 mg at 30 intervals usually abolishes all effects of Catapres, (clonidine hydrochlorid dosage.

How Supplied: Catapres, brand of clonidine hydrochloride, is available as (tan) and 0.2 mg (orange) oval, single-scored tablets in bottles of 100 and 10 available as 0.3 mg (peach) oval, single-scored tablets in bottles of 100.

For complete details, please see full prescribing information.
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Digit Replantation

Fount K. Hartley, M.D. and H. Hollis Caffee, M.D.

Abstract: Only in the last few years has the replantation of several digits become technically possible. All cases of amputated digits can be considered, but only those with the indications should be selected for surgery. The severed part, with the patient, should be brought to a medical facility without delay. In well selected patients with good post-operative physical therapy, the functional results can be expected to be good.

Replantation of severed extremities has evolved to its present state through the efforts of many surgeons. Jacobson and Suarez demonstrated the use of the operating microscope in 1960.[1] Kleinert and Kasdan reported the first successful anastomosis of a digital artery in a partially amputated thumb in 1962.[2] The first successful microsurgical replantation of a digit was that of a completely amputated thumb performed by Komatsu and Tamai in 1965. Thus, the stage was set for evolution of the art to its present degree of sophistication and its array of refined microscopes and surgical equipment.

The following case reports were selected to illustrate the indications, techniques, and typical results of digit replantations.

Case Reports

Case 1. — A 3-year-old girl amputated her left little finger just distal to the proximal interphalangeal joint when she put her hand in a floor fan. The patient and the amputated finger were brought to a community hospital emergency room. After two hours of ischemia, the finger was placed in a plastic bag and placed on ice. The replantation team at the University of Florida was consulted by telephone and it was tentatively decided to attempt replantation. The patient and the amputated finger were transferred to Gainesville by private automobile.

Immediately after arrival, the patient was prepared for surgery and the finger was taken to the operating room for debridement and dissection of the nerves and the vessels. After the patient had been anesthetized and prepared and draped, the stump was explored under tourniquet. When the vessels and nerves had been isolated and tagged with sutures, the finger was placed on the stump and held with oblique Kirschner wires across the fracture. The extensor tendon was repaired and then both digital nerves were sutured. One digital artery and two veins were repaired with interrupted 10-0 nylon sutures. The operating time was seven hours. There were no postoperative complications, and the patient was discharged on the second postoperative day.

On follow-up examination there was good healing of the wound and union of the fracture. She lacks good flexion but has normal extension and sensation, and the appearance of the hand is excellent. Two years postoperatively growth appeared to be progressing normally.

Case 2. — A 20-year-old right-handed mechanic was seen who had sustained a traumatic avulsion of his right dominant thumb at the MP joint when his hand was pulled into a rotary machine. The amputated part, badly contused and impregnated with grease, was retrieved. The patient was transferred immediately to the University of Florida hospital by helicopter and by automobile. Five hours of ischemic time had elapsed when the surgery was begun. In the operating room, two teams worked for the initial part of the operation; one group debriding the severed thumb and identifying digital arteries, nerves and veins. Both vein and nerve grafts were necessary because of the large areas of avulsion. The metacarpophalangeal joint was fused and a skin graft was required for complete coverage of the dorsum. Consequently the extensor pollicis longus was not repaired because it would have been under the skin graft. The flexor pollicis longus tendon was not repaired because of extensive damage which rendered it unsuitable for primary repair. The patient's attitude and motivation were excellent and he returned to work after four weeks. Function was excellent in spite of the fused MP joint and the lack of tendons to move the interphalangeal joint. Sensory return had begun when he was lost to follow-up at four months.

Case 3. — A 29-year-old right-handed woman sustained an accidental amputation of her right hand at the metacarpal level. The injury was caused by a commerical paper cutter and was a relatively clean amputation. She was first seen in a community hospital and transferred to a medical center which did not have a replantation team;

Dr. Hartley is Senior Fellow and Dr. Caffee is Assistant Professor in the Division of Plastic and Reconstructive Surgery at the University of Florida Medical Center, Gainesville.

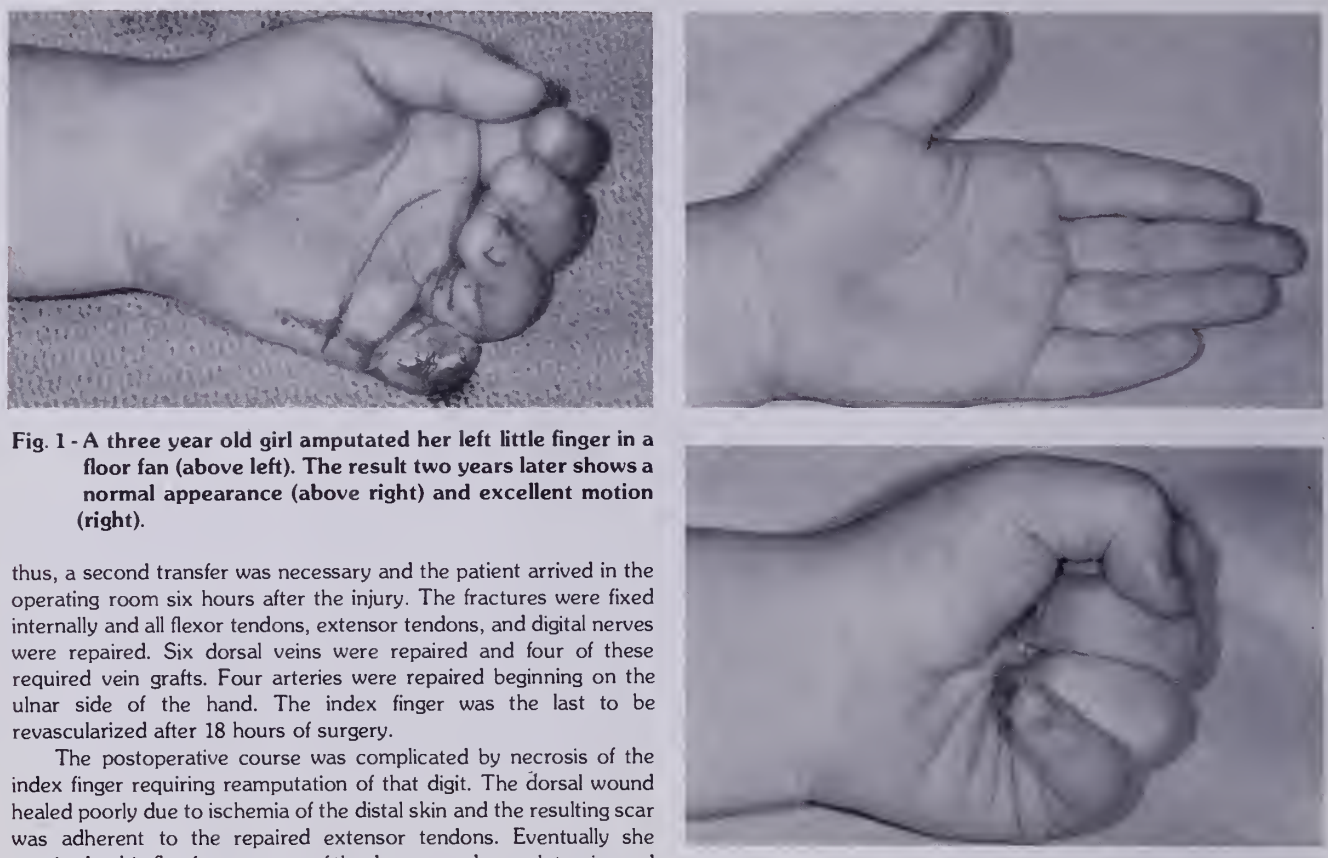


Fig. 1 - A three year old girl amputated her left little finger in a floor fan (above left). The result two years later shows a normal appearance (above right) and excellent motion (right).

thus, a second transfer was necessary and the patient arrived in the operating room six hours after the injury. The fractures were fixed internally and all flexor tendons, extensor tendons, and digital nerves were repaired. Six dorsal veins were repaired and four of these required vein grafts. Four arteries were repaired beginning on the ulnar side of the hand. The index finger was the last to be revascularized after 18 hours of surgery.

The postoperative course was complicated by necrosis of the index finger requiring reamputation of that digit. The dorsal wound healed poorly due to ischemia of the distal skin and the resulting scar was adherent to the repaired extensor tendons. Eventually she required a skin flap for coverage of the dorsum and capsulotomies and tendolysis in an attempt to remobilize her stiff hand. At six months, she had normal sensation but poor function secondary to lack of mobility. She had not returned to work.

Discussion

The operating microscope and the development of very fine sutures and needles have allowed the development of techniques to repair arteries and veins smaller than one millimeter. Replantation of major upper extremity amputations has long been possible but yields poor results because of the limitations of nerve regeneration. Amputations of digits frequently have recovery of sensation with functional results of good quality.[3] Size is no obstacle as shown clearly by case 1, and fingers can be replanted as far distally as the distal interphalangeal joint.

Not every amputated finger can or should be replanted. Clean amputations caused by sharp instruments are ideal, but avulsed fingers may be

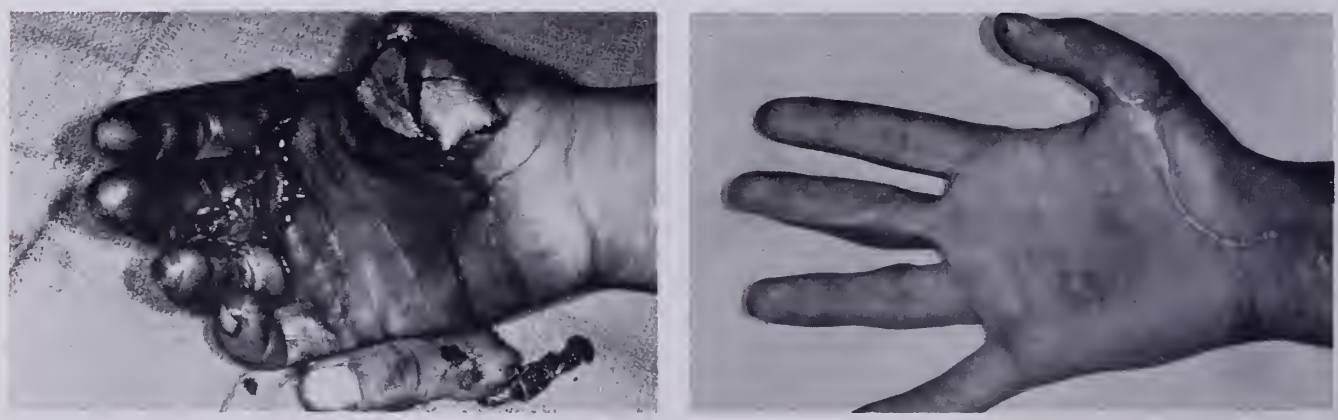


Fig. 2 - A 20 year old man with avulsion of his right thumb (above left). Six weeks later he had healed and returned to work (above right).

replantable if there has not been too much tissue destruction; this must often be decided by examination under the operating microscope. Other factors besides the presence of an amputated digit enter into the selection of cases: the patient's age, occupation, general health, local condition of the wound, and expired time since amputation. Generally, most surgeons would agree that replantation is indicated for thumb amputation, multiple digit amputation, amputations in children, and transmetacarpal (or proximal) amputations. The generally accepted contraindications to replantation include severe damage to the amputated part or other more serious life-threatening injuries. Relative contraindications include avulsion injuries, elderly patients, and single digit amputations other than the thumb, except in young children or patients in whom appearance is critical. Replantation of an isolated index finger amputation would be difficult to justify because of the excellent function and appearance following an index ray amputation. It is apparent that the duration of ischemia in the amputated digit is of considerable importance in replantation. Although replantation is possible after several hours of ischemia time, it is obvious that the chance of success diminishes with time. With cooling of the amputated part, a digit can be replaced up to or beyond 24 hours.

When the decision is made to attempt replantation, the patient is transferred to a facility with micro-surgical capabilities. The amputated part should be kept in a plastic bag and placed on ice to prolong tissue survival before replantation. The finger must not be frozen. A two-team microsurgical approach is ideal. One team cleans and debrides the amputated part while the other team debrides the amputated stump. The nerves and vessels are identified and marked with sutures. The sequence of repair generally follows debridement of the stump and the amputated part back to healthy tissue under magnification. The finger is replaced on the hand and held in place by internal fixation of the fracture. The tendons are repaired by standard techniques, and then the microscope is used to repair the vessels and nerves. Normally, at least one artery and two veins are repaired for each digit. The vessels and nerves must be trimmed proximally and distally until all damaged tissue has been removed. If there is insufficient length for repair without tension, vein grafts and nerve grafts must be interposed. All structures should be repaired at the time of replantation if at all possible.



Fig. 3 - A 29 year old woman had a transmetacarpal amputation of her right hand (top and middle photos). At three months she has limited function (bottom photo).

Broad spectrum antibiotics should be started when the patient is first seen by a physician. Careful attention to the circulation and capillary refill time to the replanted part is vital during the first few hours following surgery. Low molecular weight dextran solutions and aspirin can be used to encourage patency in the vascular anastomosis. Once survival of the digit has been assured, the patient may be treated as though he has had an ordinary finger injury, with mobilization of the digit as soon as allowed by the fracture and tendon repairs. The ultimate functional result will depend on the quality of nerve

recovery and the mobility of the tendons and joints. Rehabilitation requires considerable time and effort. Secondary operations on tendons and joints are often required. There is no question that a laborer could return to work sooner with a stump than with a replanted finger, and the economic impact must always be considered before recommending replantation.

The state of the art of replantation has come a long way since it successfully cleared the initial hurdle of surgical union of severed parts. Despite the exciting achievement of a viable replanted digit, a functional result is one of the real challenges in replantation which will probably be improved through further cumulative experiences. The Chinese surgeon, Ch'en Chum Wei, summarized the problem well when he stated that "survival without restoration of function is not success."[4]

Guidelines in the care of patients for replantation:

1. Control bleeding from the stump with direct pressure; do not use a tourniquet. Avoid clamping and tying the severed ends of vessels unless absolutely necessary. Simple elevation of the hand will usually control active bleeding and minimize edema.

2. Secure the dismembered part and place it in a clean (preferably sterile) plastic bag with a moist, sterile saline sponge wrapped around it. The plastic bag is then immersed in ice. Freezing is to be avoided. Do not attempt to clean or otherwise surgically manipulate the dismembered part.

3. If the partially severed member is still attached to the parent member by some tissue other than skin, do not sever it. Simply wrap the tissues in sterile saline and apply ice to distal portion.

4. Administer antibiotics and tetanus prophylaxis as indicated.

5. Transfer the patient with the dismembered part to a center with replantation capabilities as soon as possible.

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Congenital Heart Disease in Florida A Predictive Study

Robert S. Levine, M.D., Nigel Roberts, M.D., Shan Cretin, Ph.D., and Henry Gelband, M.D.

Abstract: An epidemiologic model is employed to estimate the number and types of patients with congenital heart disease who will require care in Florida during the year 1995. Some 10,977 persons under age 21 is the prediction, with ventricular septal defect, pulmonary stenosis, atrial septal defect, patent ductus arteriosus, and coarctation of the aorta accounting for nearly 70%. Prevalence estimates are needed in order to determine planning objectives and the effectiveness of case finding.

Estimates of the occurrence of congenital heart disease are needed to determine case finding effectiveness and establish planning objectives and priorities. Although estimates are available of the frequency of new cases of congenital heart disease,[1-3] corresponding information is sparse regarding the total number of cases present at any one time in a given locality. This is due to lack of data as to attrition expected from recovery or death. For long-term planning in delivery of health care, however, knowledge of the total number of cases present at any one time is vital to determination of budget requirements concerning distribution of manpower and fiscal responsibility.[4]

One approach to obtaining these estimates is an epidemiologic model that reflects the expected number of cases which will be present at a particular period. The purposes of this report are to use such a model to estimate the number of cases of congenital cardiovascular malformations for a given year in the Florida population under 21 years of age, and to delineate the types and frequency of each abnormality.

Methods

From predictions of the number of live births in Florida from 1975 to 1994,[5] it is possible to estimate the number of babies to be born with congenital heart disease each year.[3] The estimate for the final year and all children from previous years who enter the second year of life may then be added over a 20 year period. This total is much larger than the actual number of children with congenital heart disease because it fails to include the estimated attrition through spontaneous improvement or death. However, a knowledge of natural history and surgical management may be applied in individual cases to make the needed estimates.

Thus, for example, the total number of cases of congenital heart disease in Floridians under age 21 as of 1995 equals (the annual population for 20 years x live birth rate: 1,000) x (incidence of congenital heart disease: 1,000) minus (attrition from spontaneous improvement or death).[4] Population predictions and live birth rates may be used to compute the number of children to be born in any particular year. Incidence figures, expressing the frequency of new cases, may then be used to estimate the predicted number of cases of congenital heart disease (e.g. Table 2, column 2). Estimates of those who will fail to survive[3] may then be subtracted from the total (e.g. Table 2, column 4). Similar computations may be carried out, with appropriate adaptations as to years of survival, for all births between 1975 and 1994 to yield estimates as shown in Table 3.

Results

Live births in Florida estimated from a rate of 12.5 per thousand population and from predicted population levels are tabulated alongside representative years in Table 1. Using these estimates, the number of new cases of congenital heart disease can be predicted. An example

Table 1. — Predicted Population of Florida and Estimated Live Births[5] for Selected Years Between 1975 and 1994.

	Population	Live Births
1975	8,485,200	105,735
1980	9,432,000	117,900
1990	11,772,000	146,525

From the Departments of Pediatrics and Epidemiology, University of Miami School of Medicine, Miami, and the Departments of Pediatrics and Medicine, University of California School of Medicine and the School of Public Health, Los Angeles.

year (1975) is shown in Table 2. Data are presented in four columns. The first column gives the frequency of defects expected at birth, with the second column representing the number of children born with each defect. This is followed by the percent surviving for three years and, in the last column, the number of survivors. The overall frequency per 1,000 live births of 8.11 yields a total of 857 cases at birth, the most common being

Table 2. — Florida Children Born with Congenital Heart Disease in 1975. Expected on Basis of Data Collection by Mitchell et al,[3] 1971.

	Frequency[3] Per 1,000 Live Births	Number of Cases at Birth*	Percent Surviving at Three Year Follow-up[3]	Number of Survivors at Three Years
Ventricular Septal Defect	2.37	251	82	206
Pulmonic Stenosis — Isolated	0.66	70	84	59
Ventricular Septal Defect and Pulmonic Stenosis	0.20	21	82	17
Atrial Septal Defect — Secundum	0.61	64	71	45
Endocardial Cushion Defect — Partial	0.11	12	33	4
Complete	0.25	26	43	11
Patent Ductus Arteriosus — Isolated	0.62	66	66	43
Coarctation of Aorta — Preductal Isolated	0.21	22	0	0
Coarctation of Aorta and Atrial or Ventricular Septal Defect	0.12	13	14	2
Tetralogy of Fallot	0.29	31	60	21
Aortic Stenosis	0.29	31	100	31
Aortic and Mitral Valve Atresia	0.27	29	0	0
Peripheral Pulmonic Stenosis	0.20	21	91	19
Truncus Arteriosus	0.16	17	11	2
Coarctation of Aorta — Postductal	0.20	21	91	19
Transposition of Great Vessels — Isolated	0.14	15	25	4
Complex	0.05	5	0	0
Vascular Ring	0.12	13	14	2
Single Ventricle	0.07	7	25	2
Abnormalities of Coronary Artery	0.12	13	0	0
Double-outlet Right Ventricle	0.09	10	20	2
Pulmonary Atresia	0.12	13	0	0
Tricuspid Atresia	0.09	10	20	2
Mitral Regurgitation	0.05	5	67	3
Endocardial Fibroelastosis	0.17	18	20	4
Miscellaneous	0.05	53	32	17
Total	8.11	857	60	515

*Based on 105,735 live births[5]

ventricular septal defect. After three years, with an overall survival rate of 60%, 515 cases would remain from this original group.

Given the estimated number of cases, health care requirements can then be projected.[4] Based on such computations, Table 3 presents the predicted number of cases of congenital heart disease in Florida for 1995. In all, 10,977 cases are expected, led by ventricular septal defect (1,983), pulmonary stenosis (1,855), atrial septal defect (1,245), patent ductus arteriosus (1,193), and coarctation of the aorta (1,172). The lesions account for 7,448 cases or 68% of the projected total.

It should be emphasized that this model does not include rheumatic, atherosclerotic and hypertensive heart disease. Since accurate data are unavailable concerning the incidence of patent ductus arteriosus in premature children, bicuspid aortic valves, and prolapsed mitral valves, these conditions have also been excluded.

Discussion

These data suggest that over 10,000 Florida children may be affected by congenital heart disease in 1995. It is necessary to mention some of the limitations of this estimate, particularly in terms of its major underlying assumptions. These include a relatively stable live birth rate, an accurately predicted rate of population growth, and a stable rate as regards both the occurrence of new cases of congenital heart disease and the rate of attrition.

The live birth rate of 12.5 per 1,000 population is used because it is more likely to reflect future levels than the higher figures of the early 1970s.[5] This estimate, like those for population growth, is that of the Bureau of Economic and Business Research, University of Florida[5]. Florida.[5]

Data on the frequency of occurrence of new cases of congenital heart disease as well as survival data were obtained from estimates made by the Perinatal Research Branch, National Institutes of Health, Bethesda, Maryland.[3] These data reflect the experience of a low socioeconomic group, but are similar to data obtained from a comparable investigation which included all major socioeconomic groups with the exception of the very affluent.[4] On the other hand, a recent survey conducted by the National Center for Disease Control, Atlanta, suggests that the reported occurrence of new cases of patent ductus arteriosus and ventricular septal defect has tripled and doubled respectively during the period 1970-1976.[5] Whether this reflects better reporting or a true increase remains to be determined.

It should be reemphasized that figures used for patent ductus arteriosus in the present model do not reflect the incidence among premature infants, and that infants with bicuspid aortic valves or prolapsed mitral valves are also excluded for lack of accurate estimates.

Finally, concerning estimates of the occurrence of new cases, local validation of investigations such as the Mitchell survey[3] is precluded by lack of a registry for such problems in Florida. The same must be said for estimates of survival.

The realities of the cost of providing services for patients with congenital illnesses, as well as the potential for waste if resources exceed needs, demand an objective estimation of future manpower and fiscal responsibilities. Estimates as provided by the present model may be helpful. As new information comes to light and as new methods of treatment which affect attrition rates evolve, it would be feasible to update the model and revise estimates accordingly. Development of an integrated statewide registry for identification and follow-up of congenital anomalies would be a major step forward in providing this type of information.

Table 3. — Estimated Number of Persons Under 21 Years of Age with Congenital Heart Disease in Florida, 1995.

Rank	Congenital Anomaly	Number Cases	Percent Total Cases
1	Ventricular Septal Defect	1,983	18.1
2	Pulmonary Stenosis	1,855	16.9
3	Atrial Septal Defect	1,245	11.3
4	Patent Ductus Arteriosus	1,193	10.9
5	Coarctation of the Aorta	1,172	10.7
6	Aortic Stenosis	777	7.1
7	Tetralogy of Fallot	607	5.5
	All Other Lesions	2,145	19.5
	Total	10,977	100.0

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Laser Palliation of Bronchogenic Carcinoma

George L. Kullman, M.D.

Abstract: Through the development of a new type of surgical laser, it is now possible to remove obstructing tumors, including cancerous tumors, from the windpipe and main bronchi. This can be accomplished without operatively opening the chest cavity, but is performed through the normal passage of the throat. This is of particular value in inoperative obstructive cases of lung cancer.

Tracheobronchial obstruction by advanced tumors of the distal tracheobronchial tree is difficult to manage and, because of their location, renders elective or emergency measures almost totally ineffective.

This report describes the successful palliation by the carbon dioxide surgical laser, transbronchoscopically, of a patient suffering from squamous cell carcinoma of the carina.[1]

Case Report

The patient, a 74-year-old white male with established diagnosis of squamous cell carcinoma of the right main bronchus, had been radiated previously unsuccessfully with full dose cobalt therapy. The tumor recurred, causing obstruction to the distal trachea, with no promise of relief from tracheotomy or other surgical procedure. On October 15, 1979, the patient, severely dyspneic, was anesthetized by means of general endotracheal anesthesia. Bronchoscopic examination revealed almost total obstruction of the distal trachea immediately cephalad to the carina. The airway at this point consisted of a slit-like opening between the left tracheal wall and the tumor. Biopsy reconfirmed the diagnosis of squamous cell carcinoma.

Use of the 8 x 400 mm ventilating rigid bronchoscope revealed the lesion and the Cavitron CO^2 surgical laser was attached. With the instrument on full power, the tumor was slowly removed until both main stem bronchi were visible and ventilating. The patient's dyspnea was relieved immediately with an uneventful postoperative recovery.

Within a month, considerable and persistent hemoptysis developed. A second bronchoscopy, performed November 19, revealed considerable healing since the previous intervention; however, gross tumor was evident in both main stem bronchi and carina area. The CO^2 laser was again used to remove as much of the visible tumor as possible.

There had been no subsequent recurrence of the hemoptysis and the patient had normal airway function up to the time of his death from generalized carcinomatosis five months later.

Discussion

The successful use of the surgical laser for nonmalignant laryngeal and tracheal lesions[2-4] prompted application in this patient. The case appeared nonsalvageable by any standard modality of treatment and the CO^2 surgical laser proved an invaluable method of safely and effectively removing the obstructing portion of this tumor. The patient experienced immediate relief from obstructive symptoms with good palliation.

The 40 cm bronchoscopic attachment to the Cavitron CO^2 laser was used to expose the tracheobronchial tree under general insufflation anesthesia. Anesthetic gases were administered through the same bronchoscope with a high flow rate. The technique facilitates removal of smoke created by the laser ablation. The full 35 watt power of the Cavitron unit was utilized to destroy the tumor.

Of particular benefit was the added ability to successfully treat hemoptysis from this nonresectable lesion. Of necessity, the laser beam must be aimed through a rigid bronchoscope which limits the extent of possible excision to the trachea and main stem bronchi only. However, even within the small confines of the tracheobronchial tree, the surgical laser is a most valuable tool due to the pinpoint accuracy of the surgical ablation. Lack of postoperative tissue reaction is likewise of major importance in these minute spaces.

It is apparent that this surgical tool holds much promise in curative as well as palliative application in the laryngotracheobronchial area.

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SPECIAL ARTICLE

Immunization Rules Change

State health and education officials have changed school regulations for the 1980-81 session to require high school students to present proof of immunity to six childhood diseases before enrollment. Currently only kindergarten, first grade, and other first time enterers must document immunity.

Florida's compulsory immunization law, FS 232.032, was implemented in 1971 requiring that all kindergarten, first grade and other first-time (public or private) school enterers be immunized against vaccine preventable diseases including poliomyelitis, diptheria, measles, rubella, mumps, pertussis, and tetanus as medically indicated. The enforcement of this law by education and health departments has been very successful. In the fall of 1979, 93.7% of children entering Florida's kindergartens and first grades for the first time were fully immunized according to recommended standards. The exceptions were children who presented medical or religious exemptions.

Dr. James T. Howell, State Health Officer and director of the Health Program Office for the Department of Health and Rehabilitative Services (HRS) explained that outbreaks of communicable diseases (mostly measles) among junior and senior high students as well as in colleges around the state has prompted the change in immunization regulations.

"Because of the 1971 law we have a well immunized population enrolled in kindergarten and elementary schools, but immunity levels in the upper grades and extending into college age groups need much improvement", Howell stated. "Recent high school surveys conducted by immunization program staff show that as many as 1/3 of students in the upper grades are still lacking one or more doses of vaccine."

Many students in our middle and high school grades were born during the period from 1961 to 1968 when measles vaccines were first developed and licensed. Between 1963, when the first killed-measles virus vaccine was introduced, and 1968, when it and an earlier type live-virus vaccine were replaced with the new live-virus (further attenuated) type vaccine, there were millions of children throughout the country receiving vaccines that provided protection for only a limited period.

Twelve years experience with the new live-virus (further attenuated) type vaccines has shown them to be safe and capable of providing long lasting immunity to measles.

However, studies have shown that the age at which a child is immunized with measles vaccine is important in achieving optimum sero conversion rates.

The studies indicated that children immunized at 12 months of age, which was the recommendation at that time, or younger, were not apt to achieve maximum sero conversion as those immunized at 15 months or older.

As a result, the American Academy of Pediatrics and the U.S. Public Service changed their recommendations. It is now recommended that live (further attenuated) measles vaccine be administered to:

a. children at 15 months of age or older, and
b. those children previously immunized at 11 months of age or younger, and
c. those children previously receiving killed (inactive) measles vaccine, and
d. those children previously receiving live virus vaccine within 3 months of having received killed measles vaccine, and
e. those children receiving a measles vaccine of unknown type prior to 1968

Sine 1978 county health departments and schools have conducted special "catch up" measles immunization campaigns throughout the state in a futile effort to raise immunity levels to at least 90 percent in junior and senior high schools. On the average, about 10 percent of students participated in the voluntary programs, which does not insure a fully immunized school.

Palm Beach County was an exception. During the 1979-80 school year the school board there agreed with county health officials to make immunization of students in grades 9-12 mandatory. The plan received the active support of the County Medical Society and parents were notified to furnish proof of measles immunization — otherwise their children would be excluded from school attendance.

It worked! By November 16, 1979, 97.4 percent of the county's 25,007 students attending 38 public and private secondary schools furnished documents to prove immunity to measles. During the campaign 1,678 students were sent home for non-compliance but within days all but 300 produced their records.

About 15,000 doses of MMR/measles vaccine were administered by private physicians and the health department during the effort.

Shortly after the Palm Beach program, local officials were receiving editorial praise from the news media proclaiming that 99 percent of county teen-agers had been immunized against measles. And while over a third of Florida counties are reporting outbreaks of measles — Palm Beach County is down from a high of 316 cases in 1978 to three cases reported this year.

Howell expects the amended rules will enable physicians and county health departments to achieve a high level of immunity in all of Florida's public and private schools.

Copies of the *Compulsory Immunization Guidelines 1980-81* are being sent to county health directors, school officials, and physicians. Between now and the opening of the next school year, continuous promotion and publicity will be generated by state and local health and school officials. Local health departments will have supplies of all forms needed to implement the program and these will be available to private physicians on request.

Howell urges those responsible for health and education in Florida to follow policies and procedures which comply with the immunization law, avoid the necessity of keeping children out of school, and to pursue programs consistent with obtaining immunization of children at ages and times recommended by accepted standards of medical practice.

"A team effort will be needed", he said, "the team to consist of private physicians, schools, health units, and parents. Physicians' offices and clinics, in particular, will receive numerous requests for documentation of immunization histories and will no doubt vaccinate more children than usual this summer.

"With good effort before the next school year, the goal of virtual full immunization in all of Florida's schools will be achieved."

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TODAY'S ISSUES

Second Opinions Are Here To Stay

James F. Richards Jr., M.D.

Abstract: The recent interest and promotion of second opinions, by parties inside and outside of medicine, have precipitated sometimes emotional and confused responses. The author believes there is a place for second opinions and feels it constructive to define what that term means.

Second opinion is a term requiring some definition. There are many types of second opinions including voluntary and mandatory. Voluntary opinions may be initiated by the surgeon or the patient, and may be obtained from a similarly qualified surgeon, or from a physician in some other specialty or subspecialty regarding a problem different from the surgical one.

Since time immemorial, we physicians have sought second opinions voluntarily, either by our initiation or by request of our patients. These opinions have been sought from other surgeons prior to an anticipated operation, and sometimes from internists or other physicians regarding diagnosis, and whether the patient is in fact a safe operative candidate from a cardiovascular or other standpoint.

Mandatory second surgical opinion may mean several things. An insurance company may require second opinions prior to approving payment for a surgical procedure. The Department of HEW made it mandatory that the fiscal intermediaries from Medicare provide for second surgical opinions, although those second opinions are elective upon the request of the patient. For many years Vocational Rehabilitation in the State of Florida has been using mandatory second surgical opinions in certain selective cases, and in Workers' Compensation we have often seen the carriers require a second surgical opinion prior to authorizing a payment for a procedure.

Today we find insurance companies involving themselves in second surgical opinion programs. For several years in New York and New Jersey there were pilot programs using second surgical opinions, and these initially reported considerable savings by avoiding many surgical procedures. There were unsubstantiated reports released, and reporters and columnists concluded from these reports that there were in America a high percentage of unnecesaary operations performed. The original extrapolations from the New York and New Jersey studies were later proven to be grossly inaccurate.

Blue Cross and Blue Shield of Michigan, one of two sites chosen by HEW for extensive surgical opinion trials showed that 42% of those who sought second opinions when surgery was recommended were advised by the consultants that it wasn't really needed. However, there were only 81 cases reported for the period August 1, 1978 through June 15, 1979, representing no more than .0001% of the surgery performed during this period.

In three Michigan counties where second opinion option was available for five years to one and one-half million auto industry employees and their dependants, it was found that 27 people per 100,000 of those eligible had participated. Of 298 requested second opinions, 69% confirmed the surgery.

All of these statistics may be of doubtful value, because it is difficult to follow-up and discover exactly how many people who were advised not to have surgery actually underwent the surgery at a later date.

The American Medical Association made a statement favoring voluntary consultations for second opinions, and opposing mandatory second opinion programs. This statement was made in response to the Subcommittee on Compensation and Employee

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Dr. Richards is an orthopedic surgeon practicing in Orlando, and is Chairman of the FMA Committee on the Cost of Medical Care.

Benefits of the House Post Office and Civil Service Committee on HR 4281, a bill to provide that Federal Employee Health Plans require second opinions for elective surgery covered.

The terms "medically necessary" or "surgically necessary," and "unnecessary surgery" are not well defined and not standardized. There are obviously certain conditions which require immediate surgical attention because of risk to life, limb etc. There are situations of uncontrolled hemorrhage or interruption of airway that can be considered extremely acute. There are other emergencies including such things as compound fractures, partial arterial obstructions, major joint dislocations, etc. "Non-emergency procedure" might include laparotomies where there may or may not be serious findings, reconstructive procedures such as orthopedic and urological, hemorrhoidectomies, etc. There are many that might be semi-elective surgical procedures, and other diagnostic surgical procedures. In plastic surgery there are reconstructive procedures and purely cosmetic surgical procedures. In addition, there are a number of operations that are either obsolete or of unproven significance including such things as breast augmentation by injecting liquid silicone, kidney suspension, bone pegging of Osgood-Schlatter's Syndrome, and stimulation by ivory chips under the periosteum for leg length discrepancy.

The term "unnecessary surgery" implies to the non-medical person that the surgery is not indicated. That term has been used to describe elective surgical procedures that can be done upon the request, and at the discretion of the patient, and upon the willingness of the physician to perform such surgical procedures. At least a segment of the leadership in our country would suggest that all operations are unnecessary unless they are life saving procedures. This same segment would suggest that surgical procedures are unnecessary if they do not in fact demonstrate pathology. This hypothesis would preclude the general surgeon from exploring an abdomen unless he could be assured of finding an inflamed appendix in every case.

The rather large number of surgical procedures done in this country which are elective and done at the discretion of, and by the choice of patient in conjunction with his/her doctor include such things as elective cholecystectomy, hernia repairs, total hip replacement, bunionectomies, hysterectomy, etc. It is in this large group of surgical procedures where there has been a great effort to obtain second surgical opinions preoperatively.

It should be pointed out that as a third party responsibility for paying medical bills in this country has evolved, it is quite natural that third party payors would become concerned about the necessity of the services for which they will eventually be expected to pay. Certainly, conscientious insurance companies should be fiscally concerned about the appropriateness of services they are purchasing, and it is understandable why second surgical opinion programs have developed.

The programs vary around the country, some stipulating that only a qualified surgeon can render a second opinion, and others saying any licensed physician can render an opinion. Some plans have suggested the person rendering the second surgical opinion should not be permitted to become the treating physician, even if the patient so elects. There may be some merit in this, although there undoubtedly will be occasions when a second surgical opinion physician may very well be more qualified to render the service. This decision should certainly never be taken away from the patient in these cases, and the patient should continue to have the right to choose his or her physician.

There are those professional organizations that have condemned *all* second surgical opinion programs for the fear that there will automatically result some distrust for the patient's own doctor. There may be some truth in this fear, but most conscientious physicians would not object to a patient having another opinion if the patient requests it.

There will be an occasional physician who will use the second opinion program to increase his practice and income. Any good second surgical opinion program should be for the *benefit of the patient*. Monetary savings by the insurance companies should be a secondary factor.

In the Fall of 1978, HEW initiated a program encouraging its patients under Medicare to *seek* a second surgical opinion. From the fiscal intermediary, Blue Shield, in the first 11 months of the program, it turns out that there were nine requests per 100,000 people in Florida, excluding Dade and Broward counties. This represents approximately seven and one-half million people. The implication is that the program is very seldom utilized despite the radio, television and written advertisement program performed by the Department of HEW.

There is a Blue Shield Pilot Program of patient initiated request of voluntary second surgical opinion,

and there is for this program a panel of board certified surgeons. In the State of Florida, Southern Bell, having 79,000 clients, had in its first 13 months only 38 requests for a second surgical opinion. Five did not follow-up and obtain the second opinion, so there were 27 who did. Of these, there were nine general surgical opinions, seven of whom received the surgical opinion, and two of whom never obtained second surgical opinion, and did not have the surgery. Of the seven who obtained the second opinion, six confirmed the need for surgery, four of those had their surgery, and two did not. One was not confirmed and did not have the surgery. In orthopedic diagnoses there were nine requests, all of whom did seek and obtain a second opinion, and seven were confirmed. Of these, six had the surgery and one did not. Two were not confirmed and had no surgery. these figures would estimate four requests per 10,000 insured. The Southern Bell Program pre-surgical second opinions as initiated by the patient, is not mandatory and Southern Bell pays the second surgical opinion under the usual and customary fee schedule arrangement.

Another insurance company promotes a second opinion program allowing a specific amount of money per consultation. The specific amount of money unfortunately may be excessive in one consultation, and inadequate in another. This same program suggests that if the second surgeon disagrees and the first surgeon continues with the operation that the insurance company will pay a reduced fee to the operating surgeon.

The AMA policy of 1978 reaffirmed in 1979 states that "recognizing that the advisability of surgery or other specific therapy can be a matter of opinion, The House of Delegates of the American Medical Association; (1) reaffirms the right of the patient or the physician to seek a second opinion freely from any physician of his/her choice; (2) opposes the concept of mandatory second opinions or the imposition of financial penalties by third party payor for not obtaining a second opinion; and (3) supports the concept that when a second opinion is required by a third party, that the second opinion should be at no cost to the patient."

Basically, the medical profession in this country already renders second opinions in pre-surgical patients when initiated by the physician or patient, and probably would have no quarrel continuing to do that sort of thing regardless of who the third party insurance carrier might be, so long as that second opinion is not a mandatory requirement by the third party. Most physicians are quite willing to see pre-surgical patients for a colleague to render an opinion agreeing or disagreeing with the colleague's findings and recommendations, and to reassure the patient and family one way or the other. Certainly we should avoid any mandatory requirements in such second surgical opinion programs, and should strive to maintain the consultant's right to charge a reasonable fee and not something that is higher or lower than we would normally charge for such an examination.

Physicians of Florida have been asked by various companies to serve on panels to do second opinion evaluations. The decision to cooperate with such programs is certainly an individual one, but most physicians would decline to cooperate with such a program if it includes mandatory second opinion, or if it violates the physician's right to charge his usual and customary fee, or if it is done in such a way as to compromise the doctor-patient relationship of the original treating physician and his patient.

● Dr. Richards, 1315 South Orange Avenue, Suite D, Orlando 32806.

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Winston Churchill

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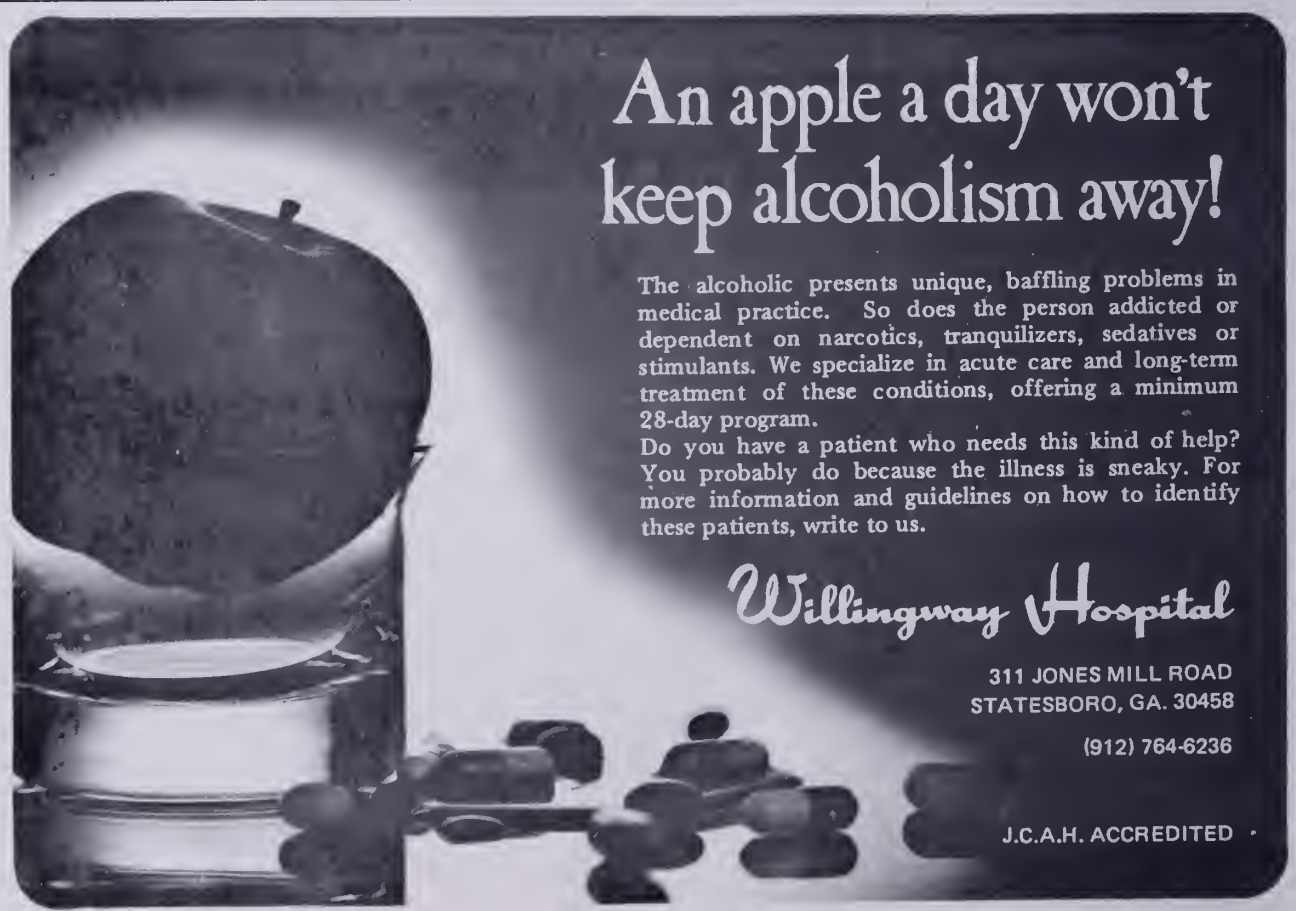
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Others Are Saying

An Unhappy Fairy Tale

"The best-laid schemes o' mice an' men gang aft a-gley,
An' leave us nought but grief and pain, for promised joy!"

Robert Burns
"To A Mouse"
Scottish Poet, 1759-1796

Edinburgh, Scotland — This is a fairy tale setting.

I am sitting in a second-floor hotel room in the Hotel Caledonia. As I gaze through the window, I view Princes Street, one of the more picturesque shopping promenades in Europe. In the distance loom two monuments. One is for Sir Walter Scott, the Gothic novelist who wrote *Ivanhoe*. The other is for Robert Burns, Scotland's renowned poet. Across the street, beautiful gardens and a park parallel Princes Street. To the right, Edinburgh Castle, a fairy tale castle if there ever was one, towers over the hotel and the city. Even the name of the hotel, "Caledonia," has a fairy tale quality. It isn't "Camelot," but it's close enough. As long as I'm in this fairy tale mood, perhaps I shall tell one.

A Fairy Tale

Once upon a time, not so many years ago, an Island Nation lay prostrate after a Great World War. Island citizens — weary of strife, improverished, exhausted, and nearly destitute — voted to reject the philosophy of their war leader. This bulldog of a man preached self-reliance, courage, tenacity, and individualism. These qualities, the citizens decided, might be good for war, but not for peace. Instead of individualism, there would be collective pooling of decisions, wisdom, and resources. Because of the perfectibility of man, equality and harmony would reign.

Their war leader warned them of their folly.

"I do not believe in the power of the state to plan and enforce. No matter how numerous are the committees they set up or the ever-growing hordes of officials they employ or the severity of the punishments they inflict or threaten, they can't approach the high level of internal economic production achieved under free enterprise.

Personal initiative, competitive selection, the profit motive, corrected by failure and the infinite processes of good housekeeping and personal ingenuity, these constitute the life of a free society. It is this vital creative impulse that I deeply fear the doctrines and policies of the socialist government have destroyed.

Nothing that they can plan and order and rush around nor forcing will take its place. They have broke the mainspring, and until we get a new one, the watch will not go. Set the people free — get out of the way and let them make the best of themselves.

I am sure this policy of equalizing misery and organizing scarcity instead of allowing diligence, self-interest and ingenuity to produce abundance has only to be prolonged to kill this British Island stone dead."[1]

He spoke well, as a Prime Minister should.

But the citizens did not listen. They would achieve social justice, equality, and security through central planning. One of their great economists, who was later to win a Nobel Prize, predicted social planning would endanger freedom, and would be the road to serfdom.[2]

Still they did not heed. The new leaders nationalized factories, trains, and mines. But the greatest gift to themselves was Free Health Care: Ah, what a beautiful word — "Free". Thereafter no one need worry.

Embarrassing questions, such as "who can pay?", "who shall go to the hospital?", or "who shall live?", need not be asked. Now one could simply ferret out those patients with sickness, care for them, and cure them.

There would be less sickness, financial burdens would be lifted, and all would be well. Free care would be brought within reach of the whole population. The care would be universal, comprehensive and without charge. it would be an act of pure generosity — of entitling people to their right of health.

Only a few details needed to be worked out: (1) nationalizing all hospitals, (2) making all doctors government employees; and (3) organizing the system. The latter would be easy. Separate free care into three parts — a hospital service, general practitioners service, and a public health service.

But details would not matter, for given the perfectibility of collective leadership and the citizens' desire to work for the common good, a Great Plan would evolve.

This Plan would be rational, comprehensive, organized, coherent, equitable, and systematic, rather than being left to the vagaries of individualism or to the market place. All collective problems, in short, would be handled rationally for the common good with complete foresight. And the citizens would live happily ever after in good health.

A Week in Scotland

Or at least that is the way it was supposed to be. After spending a week here — visiting hospitals, reading Scottish newspapers, perusing British books and the health system, talking to patients and doctors, and watching the televised proceedings of the Conservative Party Conference — In Blackpool, England, I think I can safely say: (1) something has gone wrong with the fairy tale; and (2) health planning is not what it was cracked up to be. As an American physician who believes that no amount of government planning can match the flexibility, choice, and quality of a mixed health system, with a dominant place for private practice, I am hardly an unbiased observer of the health scene here.

Observations on System

Yet, I am sure enthusiasts and critics would agree on these observations on the National Health System:

1. Central health planning has unforeseen consequences. Instead of lessening the demand for health services, the demand has increased enormously — so much so that rationing must accompany "free" health care. This rationing applies particularly to elective surgery, which has waiting lists of months to years. The waiting list for hernias, hemorrhoids, gallstones, hip replacements, varicose veins, and tonsillectomies has grown by 40 percent in the last two years and now includes almost over 750,000 people.[3] Because of increased demand, the cost ($18 billion a year) of the NHS strains the national budget and has resulted in either cutbacks (i.e., hospital building) or charges for services (i.e., dental services and spectacles).

2. A government health service can never be totally comprehensive. This lack of comprehensiveness goes beyond elective surgery. For example, the National Health Service does not provide routine physicals, most nursing home care for the elderly, screening for disease, or enough abortion services (private practitioners perform 60 percent of abortions).

3. Private health care is growing in Britain. Two and one-half million citizens belong to private health plans; unions and corporations (Electrical and Plumbers Trade Union, Birmingham brewery workers, London taxi drivers, and IBM employees) have private health plans as a fringe benefit; and the number of private hospitals, now 117, is growing at 10 percent a year.[3] To help the private health care along, the Conservative government is going to make private health care benefits tax deductible.

4. Most of the people like the National Health Service, yet most of the physicians dislike it. This should come as no surprise, since any "free" government health service inevitably is a politician's dream and a physician's nightmare. Poll after poll indicates the British public likes the idea of accessibility to general practitioners and the absence of worry of hospital costs. The English, who have had "to make do" and "queue up" for forty years, are not concerned about quality or efficient care. The following passage, from the *Changing National Health Service*, a book that favors NHS, nicely sums up patients' attitudes.

"The general public like the NHS. But since their attitude is so very unsophisticated, it is not very clear what is liked. It does not seem to be modern efficient care. Most patients seem to be more concerned with externals like communication, friendliness, accessibility and physical comfort more than the quality of examination and treatment. It follows that most patients do not know what is good for them in a medical sense."

As for doctors, their morale is low. As Powell, the Minister of Health in 1966, said, "One of the most striking features of the National Health Service is the continual, deafening chorus of complaint which rises day and night from every part of it. It is a unique spectacle of an undertaking that is run down by everyone engaged in it."

Most of the funds of the Service go to hospitals, and therefore, the general practitioners, who do not do any work in hospitals, are cut off from training, facilities and professional stimulus. General practice, particularly in rural Britain, has little appeal, and London has three times more than outlying regions. The lot of the consultant, who works in a hospital is better but not much, for consultants must participate in the bureaucratic decision making. Pay for the average physician is low, less than three times that of a manual laborer, and somewhere between one-third to one-half of European, Canadian, or American counterparts. As a consequence, more physicians are joing Unions and are demanding shorter working hours.

Physician migration rates are high, as many as 30

percent of physicians trained in England's medical schools practice abroad.[5] Who replaces these physicians? Indians and Pakistani physicians comprise 75 percent of hospital junior staffs and fill the ranks of general practitioners.

5. The public and the profession have different expectations of what the Service should provide. The public wants amiability, accessibility, and conveniences, and physicians desire better facilities, more sophisticated diagnostic equipment, freedom in decision making, and more efficiency and effectiveness in putting their training to good use. These different expectations led to bureaucratic and managerial conflicts. Physicians feel committee work is a waste of their skills and lowers the quality of care by diminishing the quantity of time devoted to it. Many of the bureaucrats, on the other hand, feel that equality, not quality, is what counts.

These differences in goals led to frequent "directives" to doctors from the Health Ministry. The intent of these directives was to force physicians to comply with the rules. Instead they led to delays, to inefficiencies, and to reorganizations to correct these inefficiencies. By the early 1970s, 625 different organizational bodies, ranging from regional hospital boards to local health authorities, each with overlapping boundries of authority and geography, were trying to run the Service. In 1974 the Service was reorganized into 90 area health authorities (AHAs), each responsible for "meeting the total health needs of a defined population".

In addition, this reorganization supposedly unified the hospital, physician, and public health services. This all sounds plausible, but the Service is continuing to suffer a succession of labor disputes, budget restraints, and managerial crises. These events not only remind me of Churchill's words, quoted earlier, but of those of Milton Friedman, the Conservative economist:

"Government can never duplicate the variety and diversity of individual action. At any moment in time, by imposing uniform standards in housing, or nutrition, or clothing, government could undoubtedly improve the level of living of many individuals; by imposing uniform standards in schooling, road contruction, or sanitation, central government could undoubtedly improve the level of performance in many local areas and perhaps even on the average of all communities. But in the process, government would replace progress by stagnation; it would substitute uniform mediocrity for the variety essential for that experimentation which can bring tomorrow's laggards above today's mean."

In Britain's National Health Service, a kind of paralysis by analysis, and planning for stagnation has set in. Every one, of course, has to be a planner to some degree and no one can object to planning in a general sense. But what planners fail to mention is that planning too often is done by those removed from what they are planning, and by those who fail to realize individual creativity, innovation, and choice are necessary for excellence. Too often, "planning" is a euphemism for regulating, controlling, and rationing resources and services through committees, forms, and procedures. Too often, planners neglect results, consequences and quality. Instead of achieving equity and access, they commit society to, at best, a competent mediocrity.

6. Hospitals are deteriorating. Fifty percent of British hospitals are of pre-1918 vintage, and more than 70 percent are pre-1948. Even though 55,000 beds were replaced between 1966 and 1975, only a quarter of the total beds are in post-World War II buildings. Hospital construction is now almost at a halt. Even at the peak of building activity, 1966 to 1975, beds were only being replaced at a rate which would have allowed replacement every 55 years.

7. Government health plans, once instituted, are difficult to change. The new Prime Minister, Margaret Thatcher, has introduced these general policies — tight monetary control, reduced government spending, cutting income taxes, raising sales taxes, and reducing government health and welfare services. She plans to do the latter by reducing welfare benefits, by cracking down on foreigner's use of the NHS, by closing marginal hospitals, by abolishing one of "tiers" of hospital administrators — the local health authorities, by reducing paper work, by reversing the trend towards centralized hospitals, by abolishing maternity grants, by raising pension age for women from 60 to 65, and by having employers pay for the first six weeks of employees' sickness benefits. The Conservative government may cut 10,000 to 20,000 administrative positions from the Service. According to Conservative Michael Carter, "the service has grown fat on an administrative bureaucracy, which instead of getting to grips with its problems, occupied itself with the reorganization of inefficiency."

Will the Health Service be cut? I'm doubtful. To talk in the United Kingdom of cutting health services is still tantamount to questioning the virtue of the Queen. The National Health Service is the jewel in the crown of socialism, and, as the labor party spokesmen are fond of saying "must not be dismantled." When Margaret Thatcher raises the prices for dental fees or spectacles, or when she threatens to close day-care centers, she is disdainfuly denounced as "Atilla the Hen", presumably because she is disturbing the pecking order of the Health Service bureaucracy.

8. The problems of the National Health Service cannot be considered apart from the "English disease" — lack of productivity. Lack of productivity has many roots: Too much state intervention. Expensive welfare programs. Heavy tax burdens.(the government takes 60

percent of national income). Low income (only one percent of Britons earn over $14,000 while the U.S. median income is $13,000). Strident trade unionism. Lack of incentives (the government confiscates 98 percent of profit). These policies shrink the national income and produce stagnant growth. Little money remains for the Health Service. Trade unions aggravate the productivity problem. At one point a year or so ago, ambulance drivers, orderlies who wheeled patients to surgery, and nurses were on strike. Because of frequent strikes, it sometimes takes seven to ten years to build a hospital. In one hospital I visited, laboratory computer programmers left in a pay dispute three years ago and never returned. Add to these policies and problems an inflation rate of 17 to 20 percent, and you can see why stagnation and drifts that beset the national economy drag down the health system.

Lessons for America

Are there any lessons for America? A couple. One, don't expect too much from PL-93-641—the law passed by Congress in 1974 that set up the 205 Health Service Areas (HSAs) in the U.S. Centralized or regional health planning can never efficiently replace local market forces. At least, that law acknowledged that health reform could not be done by government alone since it calls for participation by many non-government groups. Two, maybe America has been smart to have the long debate and delay of National Health Insurance. We have had the opportunity to look more deeply into our own experience with government health programs and to the experiences of other governments. Now, even passionate liberals have discarded thoughts of complete reliance on the public medical service approach. Skepticism grows among the public about government's ability to deliver on its promises. If my experiences on my recent Scotland trip and on my other four trips to the United Kingdom are any barometer, the public has good reason for its skepticism.

Richard L. Reece, M.D.

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Ethics, Fiscal Practices, and P.R.

Recently the CMS Board of Governors was asked to consider making a firm policy statement regarding certain business practices that seem to be gaining popularity among some doctors. These practices are the cause of many complaints which come to the attention of the medical society office. The three commonest are the demanding of "cash in hand" before the patient is seen, using the threat of a collection agency as a club to facilitate collections, and the refusal to accept assignment of Medicare Benefits. The question being asked is whether or not these practices are ethical. The common demoninator among them however, is not ethics but public relations and what is being done to our already tarnished image.

The Board of Governors discussed these items at length and felt that there was a consensus, although they did not believe it to be appropriate to make a flat policy statement either condemning or endorsing these actions. I was therefore asked to present the consensus to the membership. That is what this is about. Being myself, however, I have superimposed and integrated some of my own thoughts.

I have sought an explanation as to why these questions have arisen and become problems and believe it is to be found by examining a very complex set of factors that have combined to create a wholly new climate about the practice of medicine. Let's look at the way it was, the way it is, and then try to determine if there is a thread of meaning that continues unchanged through both patterns.

It was not long ago that when an individual was identified as a doctor, it was fairly clear to all what he did.

One medical practice differed little from another. The patient at that time, determined his medical need and sought the doctor's assistance when he perceived that the need was worth the price, or, in extremis, that the need was so overwhelming that the doctors charity must be called upon. Thus it was for so many generations that the physician become stereotyped, both within the profession and in the mind of the public. Medicine was not just a vocation. It was a calling, when required not only special intellectual learning and training, but also demanded an individual of unusual moral character and unique personality attributes. Such a combination of requirements demanded a code of ethics which could be followed by all members of the profession. If Medicine were a calling, then it follows that it was a privilege to serve and with that privilege went the obligation to adhere to prescribed ethical behavior.

That was the way it was, but in a few years, such sweeping changes have taken place in the way medicine is practiced as to alter the picture entirely.

Today there is such a fragmentation of patient care as to abolish any similarities between one type, style, and manner of practice and another. What similarities are there among the practices of anesthesiologists, cardiologists, orthopedists, pulmonary specialists, psychiatrists, and on and on. They are so dissimilar that what is of vital concern to one specialty is hardly worth noticing to another. We really have lost our cohesiveness, that bond of common profession. I saw this illustrated at a recent meeting of the FMA Council on Specialty Medicine. This body should be the unifying voice of our fragmented profession but what I heard and saw were, (1) tunnel vision, (2) pious pronouncements not in keeping with reality, and (3) recommendations for the "good of our patients" which came out sounding like plain economic self-interest.

That seems to me to be where we are. What put us there? In my opinion, the main cause of our fragmentation and emotional dispersion is the increasing dominence of technology in our society. As doctors, the services we provide are becoming more and more technical in nature and we are becoming more and more dependent upon technicians in order to function. Our fields of action have become narrowly circumscribed. The person-to-person interaction with the patient is becoming less a factor in our practices. We are dealing primarily with things, tests, and results and only secondarily with an individual. But wait, what about those doctors who are not in a highly technical specialty? What about those who are providing or who are close to primary care? Well, I believe that the glitter has spilled over. I see an attempt to eliminate those difficult and undesirable patients, to work strictly by schedule at our convenience, not for the convenience of the patient.

A final factor that has altered the medical practice climate has been the development of a whole new industry, diverse in nature but with one point in common. The people who comprise this industry are dependent upon doctors' high income for their support. They are the practice consultants, business managers, investment counsellors, computer services, travel and seminar brokers, and the list can go on and on. They are all dedicated to one thing, greater income for the doctor, and to do this they have converted the practice of medicine into an efficient commerical enterprise.

So much for where we are. I said I was searching for that thread of unity that passed through the whole fabric. The thread that I see is the physician image, the stereotype. The patients still want to view us in such a way and want to be treated in the way such a figure would treat them. The doctors too, want to be visualized as being the classical, stereotypical physician and want to be treated in the manner such a physician would be treated. We have an identity crisis. We have been sold the new identity as an entrepreneurial businessman but we can't escape the stereotype.

In the old business climate, certain business rules were generally accepted. It was felt that medical fees were high enough to compensate for the uncollectables. Surgical fees were sufficiently high to accomodate for the fact that sometimes the operation would be easy and sometimes it would be difficult. Ability to pay was a factor which could rightly be considered in establishing a fee. We should reexamine these attitudes in today's climate. They are still valid.

With the foregoing in mind, let's look at the questioned business practices. The requirement that payment accompany service was addressed recently in a question and answer panel in one of our medical publications. The panel felt that it could be acceptable in the case of a new patient previously unknown in your practice and on the occasion of the first visit, but that it would be counterproductive if applied on subsequent visits. Recognizing that today there is need for strict adherence to sound business principles, the Board of Governors felt that the policy itself was not as much the issue as the manner in which it is administered. At the heart of all these questions is the way the patient perceives us. Is our main interest in the patient? Or are we concerned first that we get our fee, with the patient being merely a means to that end? Regardless of our policies, the way we come through lies in the hands of our front office personnel. They can make a poor policy palatable and conversely can destroy our image with maladministration of good policy, but because it is in their hands doesn't get us off the hook. They are the extension of us. We must know how they are coming through and if it is not good, we must provide the

example and the training. No policy is good and no administration of it is acceptable that fails to consider that there will be some poor people in need of our services. If they are made to feel unwelcome solely because they lack our fee, then a disservice has been done to our profession.

A similar attitude should prevent the other two questions from becoming problems. On the face of it, there is nothing unethical about utilizing the services of a collection agency, provided the agency uses only ethical techniques. However, a distinction should be made between those patients who can pay and don't and those who are destitute and can't adequately provide food, clothes, or shelter. Clubbing these with collection threats gains nothing, but it further blackens our image.

Likewise it is not a matter of ethics, in an individual case, to refuse assignment of Medicare benefits but in many instances it can be disastrous public relations. The way it is done is so important.

As I said, I believe there is a thread of continuity appearing in medical practice as it was and continuing on into medical practice as it is. The thread is the physician image. As reinforcement, the AMA has given us "Principles of Medical Ethics". This is not a code to which we must swear allegience in order to belong to the club. In format, the code is set forth as a preamble and ten sections. These then are further elaborated upon and made more specific through "Opinions and Reports of the Judicial Council", dealing with specific problems and questions which have been placed before it. I am surprised at the numbers of our colleagues who are not even aware of the existence of this document. I would like to quote from the Preamble and paragraph 2 under section 1 as being particularly appropriate to this subject.

"These principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws but standards by which a physician may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions, and with the public."

Sec. 1, P. 2. "Ability of Patient to Pay"

One of the strongest holds the profession has on public approbation and support has been the age-old professional ideal of medical service to all, whether able to pay or not. The ideal is basic in our ethics. The abandonment of that ideal and the adoption of a principle of service only when paid for would be the greatest step toward socialized medicine which the medical profession could take. All our arguments as to better service to the people, freedom of choice of physician, individual service, and maintenance of high grade medical service by highly qualified physicians would be as naught if such service were not available to a vast proportion of the people" (From 1972 edition)

I believe that we are now practicing under the greatest possible system but I also believe that it can be destroyed. If it is, the alternative will be regulatory commissions, across the board fee schedules for all, or perhaps salaried practices. Perhaps it is not too late.

James K. Conn, M.D.

Presented by James Conn, M.D., to the Capital Medical Society, February 11, 1980.

The best way to get and keep good people is to give them room to grow.

FMA AUXILIARY

Auxilians Get Into The Act



Mrs. Swing

The 1980-81 theme for the Florida Medical Association Auxiliary is "Get Into The Act" for medicine. Each auxilian is encouraged to take an active role in promoting the programs and projects of the organization. This is a critical year politically, economically, and health-wise. The Auxiliary stands ready to aid the FMA and county medical societies in whatever capacities the physicians deem most effective.

The Florida Medical Association Auxiliary, fourth largest in the United States, is composed of persons with considerable expertise in many areas. Its membership includes executives, educators, health professionals, lawyers, speakers, homemakers, business people, and community leaders. At the AMA Leadership Conference in Chicago, February 1980, the Auxiliary was characterized as the "single most unused resource" of the medical profession. This is not the case in Florida. The FMA and FMA Auxiliary have worked in concert for quite some time. This cooperation is certain to thrive and increase.

To better utilize its capabilities, the Auxiliary is conducting an extensive "Talent Search", directed by chairman, Mrs. Robert Busard. The committee is attempting to canvass the largest possible segment of the membership. Results will be tabulated into a cross-indexed reference file called the State Talent Bank. This bank should enable the Auxiliary to make its activities more relevant for members. It will facilitate state and county projects by providing a realistic means of fitting "the proper person to the proper job". The Talent Bank will be available for use by state and county auxiliaries and by the FMA.

In 1980-81 the Auxiliary's emphasis on the "Shape Up For Life" campaign will be physical fitness. Members are encouraged to undertake a regular program of proper exercise. If we are to promote good health in our communities, we must set a good example. Physicians and spouses throughout Florida are involving their entire families in organized exercise from jogging, to swimming, to tennis. The choice of activities is endless.

Child Abuse chairman, Mrs. Arthur L. Trask, has enlisted the cooperation of the Department of Education, Tallahassee, in distributing the bulletin, *Beyond Education*, to all Florida public school teachers, kindergarten through sixth grade. The pamphlet, published by the FMA Auxiliary, will be given to teachers, grades seven through 12 in 1980-81. County auxiliaries are involved in Child Abuse programs suited to their areas.

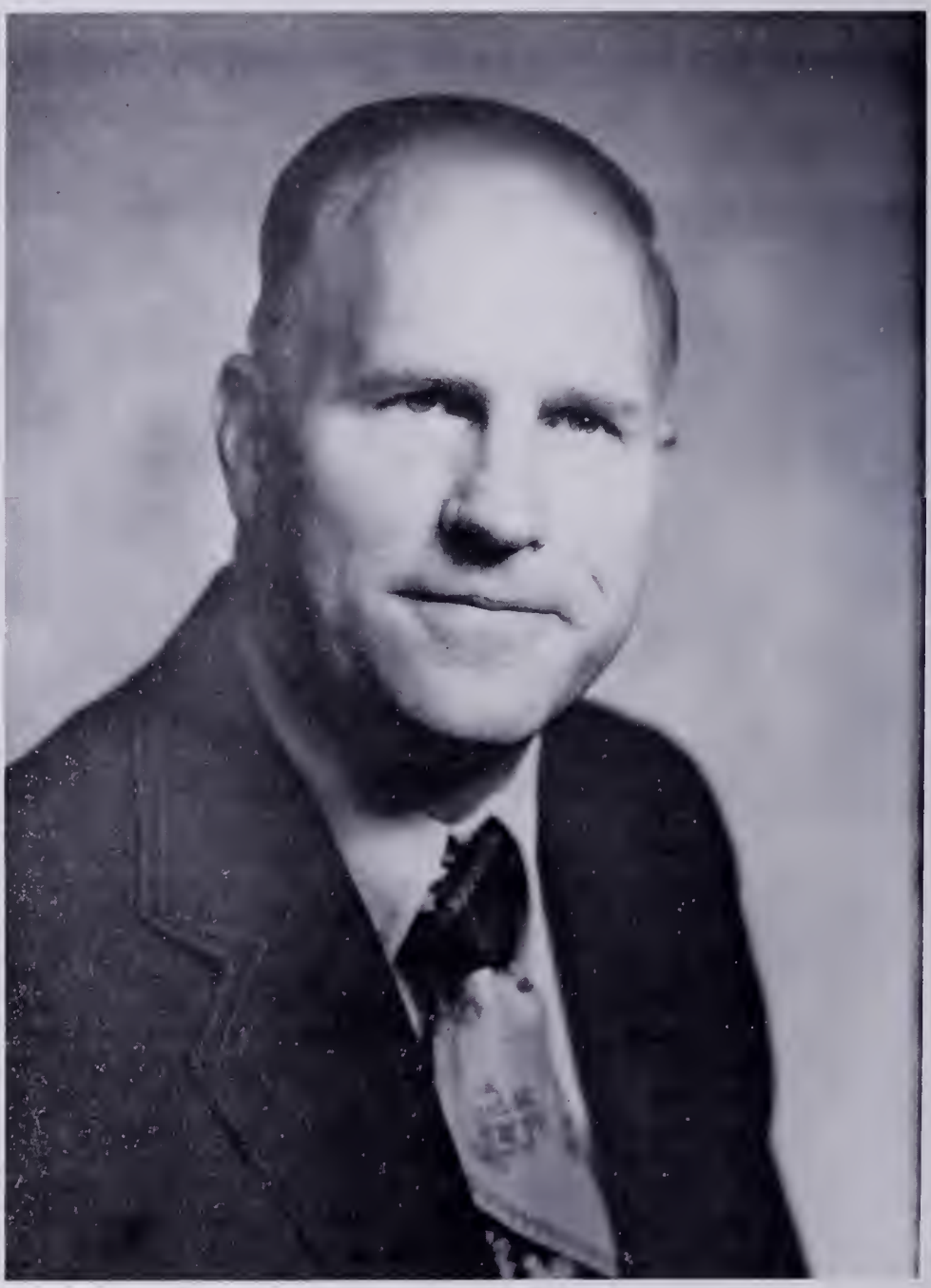
Legislative interest is keen in auxiliary circles. Supporting and promoting the position of the FMA is top priority. Highlighting this effort is strengthening of the "Legs Alert" system and the "key contact auxilian" program. Legislative chairman, Mrs. James White, encourages commitment of each member to personal research and involvement on critical issues.

Mrs. Frederick Weigand, Impaired Physicians Chairman, is working closely with the State Medical Association. This ensures that Auxiliary activities in the program will be in exact conformity with the philosophy of the FMA. Counties receive their guidelines from the state chairman. The Auxiliary's function is mainly educative.

The FMA Auxiliary has grown to over 5,400 members. This is a welcome increase because a great deal of person power is needed to "get our act together" and make this year's production a success. AMA-ERF, FMF, Health Education, and all the other Auxiliary programs will receive maximum effort. With the enthusiasm and dedication displayed by our membership, 1980-81 promises to be one great year!

Mrs. Fred P. Swing (Anne)
President
Florida Medical Association Auxiliary

ORGANIZATION



Thomas Byron Thames, M.D.

Thomas Byron Thames, M.D.

The Florida Medical Association is proud, and honored, to have as its new President Thomas Byron Thames, M.D. of Orlando, Florida.

Dr. Thames was born in Alabama, grew up in Florida, received his pre-medical education at the University of Florida and graduated from Duke University School of Medicine in 1955. He commenced his internship, in medicine, at Duke Hospital, joined the United States Air Force and completed a rotating internship at Walter Reed Army Hospital, Washington, D.C. Following active military service, as a Flight Surgeon for two years, Dr. Thames returned to Florida and joined the Orlando Clinic (headed by Duncan McEwan, M.D., Past President of FMA) in 1958.

While pursuing an active and productive medical practice, as a Family Practitioner, Byron quickly and unselfishly gave his time and energies to the cause of organized medicine. His innate leadership qualities and capabilities were repeatedly called upon by his fellow professionals.

He served as President of the Orange County Medical Society in 1970, as well as President of the Florida Industrial Medical Association in the same years. He was elected to the Executive Committee, of the Board of Governors of the FMA in 1973—and has rendered distinguished service to the FMA in that capacity, until the present. Byron has also served as President of The Florida Academy of Family Physicians (1976-77) and as the President of the Orange Memorial Hospital staff. In addition he has served on many committees and councils of the FMA throughout the years. He is currently serving organized medicine as Alternate Delegate to the AMA and is a member of the AMA Speakers Bureau.

Dr. Thames and his wife Patricia Lee (she is past President of the FMA Auxiliary), are the parents of three children. Randy, a graduate of Duke University, Thom, a student at Duke Medical School, and Helen, a student at the Community College in Orlando.

Dr. Thames' activities in the area of community service have been many. He was president of the Rotary Club of Orlando 1967-68, a member of the Central Florida Development Committee, Board of Directors of Good Will Industries, Meals on Wheels and many other service organizations.

Byron's corporate medical activities include the medical directorship of Walt Disney World, Sea World, National Standard Life Insurance Company, Coca-Cola Food Division, Circus World...to name a few.

Not only does Dr. Thames bring to the office of the Presidency of FMA a wealth of experience in community and health affairs, but provides a unique talent in the areas of strong progressive leadership, with an analytical approach to problem solving. We are confident that the FMA is in good hands with such as Byron Thames at the helm.

Louis C. Murray, M.D.
Past President, FMA
Orlando

Nothing will ever be attempted if all possible objections must first be overcome.

Samuel Johnson

This is not an easy time for her to stop smoking.

But it's not a good time for her baby to start.

The facts are in.

FACT: Women who smoke during pregnancy have smaller and lighter weight full term babies.

FACT: Their babies have more respiratory problems during the first critical years.

FACT: The incidence of stillborn infants and neonatal deaths is significantly greater.

FACT: The fetal oxygen supply is significantly reduced—the carbon monoxide in the blood significantly increased. There's more. Much more. Discuss the smoking hazard with your patients who are pregnant or planning a pregnancy. It may not be an easy time to quit smoking. But it's the right time.



U.S. DEPARTMENT OF HEALTH
Office on Smoking and Health
Public Health Service Rockville,

Some people can't see our name.

Prevent Blindness.

Every 12 minutes someone goes blind. Yet, half of all blindness is needless. Early eye care for children can correct amblyopia. Glaucoma can be arrested... sight lost to cataracts, restored. Blinding eye injuries can be dramatically reduced by safety precautions. These all add up to saving precious sight. For more information write: National Society for the Prevention of Blindness, 79 Madison Avenue, New York, NY 10016.

PREVENT BLINDNESS®

Pioneers in Medicine For the Family

BOOTS PHARMACEUTICALS, INC.

Operating in the U.S. since 1977, Boots is a world-wide leader in pharmaceutical research and manufacture. Boots has directed its efforts toward providing products useful in the practice of family medicine.

Some of our better known products are Ru-Tuss® and Ru-Vert® . This advertisement highlights three other products particularly useful for the family.

F-E-P CREME® **TWIN-K®** **SU-TON®**





For the Majority of Steroid-Responsive Dermatoses* Seen in Family Practice

F-E-P CREME®

(Iodochlorhydroxyquin—Pramoxine HCl—Hydrocortisone)

The 4 in 1 Corticosteroid Cream

Anti-inflammatory, antifungal, antibacterial actions, and, uniquely, a topical anesthetic for immediate relief of the itching or burning that frequently accompanies skin problems. One size (1/2 ounce), one strength for ease of prescription.

*This drug has been evaluated as possibly effective for these indications. See prescribing information on last page of this advertisement.

For Potassium Supplementation

TWIN-K®

Each 15 ml supplies 20 mEq of potassium as a combination of potassium gluconate (15 mEq) and potassium citrate (5 mEq) in a sorbitol base.

The good tasting potassium supplement

- Designed for prophylactic use with diuretics and adrenocorticoids.
- Pleasant taste and convenient b.i.d. dosage aid patient compliance.
- Avoids the problems of a chloride salt.

"The organic salt can be given as a liquid without producing significant gastric symptoms and without an untoward effect on the mucosa of the small intestine."[1]



Note: In hypokalemic hypochloremic alkalosis, potassium chloride supplementation may be preferred.

1 Beeson-McDermott, Textbook of Medicine, 15th Ed 1979, W.B. Saunders Co., Philadelphia, p. 1959

See prescribing information on last page of this advertisement.

or the Geriatric Patient

SU-TON®

quid Tonic

pleasant tasting prescription tonic containing iron, vitamins, inerals, an analeptic and 18% alcohol. Ideal for those who ay benefit from vitamin deficiency prevention. Just one blespoon before each meal.

ach 45 ml (3 tablespoonfuls) contains:

ntylenetetrazol	30 mg
acin	50 mg
amin B-1	10 mg
amin B-2	5 mg
amin B-6	1 mg
amin B-12	3 mcg
oline	100 mg
ositol	50 mg
anganese (as Manganese Sulfate)	1 mg
agnesium (as Magnesium Sulfate)	2 mg
nc (as Zinc Sulfate)	1 mg
n (as Ferric Pyrophosphate, Soluble)	22 mg
cohol	18%

e prescribing information on last page of this advertisement.





Please send me patient starter samples of:

☐ **F-E-P CREME®**

☐ **TWIN-K®**

☐ **SU-TON®**

Name _____

Street Address _____

City _____ State _____ Zip _____

F-E-P CREME®

DESCRIPTION: F-E-P Creme is a topical water soluble anti-inflammatory, anesthetic, preparation intended for treatment of various inflammatory skin disorders. The drug contains the following active ingredients:

Iodochlorhydroxyquin	3.0%
Pramoxine Hydrochloride	0.5%
Hydrocortisone	1.0%

INDICATIONS AND USAGE:

Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, FDA has classified the indications as follows, "Possibly effective": Contact or atopic dermatitis; impetiginized eczema; nummular eczema; infantile eczema; endogenous chronic infectious dermatitis; stasis dermatitis; pyoderma, nuchal eczema and chronic eczematoid otitis externa; acne urticata; localized or disseminated neurodermatitis; lichen simplex chronicus; anogenital pruritus (vulvae, scroti, ani), folliculitis; bacterial dermatoses; mycotic dermatoses such as tinea (capitis, cruris, corporis, pedis); moniliasis, intertrigo. Final classification on the less-than-effective indications requires further investigation

Pramoxine Hydrochloride promptly relieves pain and itch. This compound may be used safely on the skin of those patients sensitive to the "caine" type local anesthetics.

CONTRAINDICATIONS: Hypersensitivity to F-E-P Creme, or any of its ingredients or related compounds; lesions of the eye; tuberculosis of the skin; most viral skin lesions (including herpes simplex, vaccinia and varicella).

WARNINGS: This product is not for ophthalmic use. In the presence of systemic infections, appropriate antibiotics should be used.

USE IN PREGNANCY: Topical steroids have not been reported to have an adverse effect on pregnancy. However, fetal abnormalities have been produced in pregnant laboatory animals that have been exposed to large doses of topical corticosteroids. Drugs of this class should not be used extensively during pregnancy.

PRECAUTIONS: F-E-P Creme may be irritating to the skin in some patients. If irritation occurs discontinue therapy. Staining of clothes or hair may also occur with use of this preparation. Although systemic toxicity has not been reported with this drug, adrenal pituitary suppression is possible, especially when the drug is used extensively or kept under an occlusive dressing for a prolonged period. Iodochlorhydroxyquin can be absorbed through the skin and interfere with thyroid function tests. Therapy with this preparation should stop at least a month before performance of these tests.

The ferric chloride test for phenylketonuria (PKU) can be positive if F-E-P Creme is on the diaper or in the urine. Prolonged use of this drug may result in an overgrowth of nonsusceptible organisms requiring appropriate therapy.

ADVERSE REACTIONS: Skin rash or hypersensitivity may occur following topical application. The following local adverse reactions have been reported with topical corticosteroids, especially under occlusive dressings: burning, itching, irritation, dryness, folliculitis, hypertrichosis, acneiform eruptions, hypopigmentation, perioral dermatitis, allergic contact dermatitis, maceration of the skin, secondary infection, skin atrophy, striae, miliara. Discontinue therapy if untoward reactions occur.

DOSAGE AND ADMINISTRATION: Apply a thin layer of the drug to affected parts 3-4 times daily.

Note:

1. **F-E-P Creme** is distributed with 3.0% iodochlorhydroxyquin for use when antibacterial/antifungal activity is desired.
2. **F-E-P Creme (Plain)** is the regular formulation, but without iodochlorhydroxyquin.

Both of these preparations contain pramoxine hydrochloride, which has topical anesthetic properties. Pramoxine is not chemically related to benzoic acid or amide type topical anesthetics. Patients can tolerate pramoxine although they may be sensitive to other "caine" type of topical or local anesthetics.

HOW SUPPLIED:

F-E-P Creme	F-E-P Creme Plain
½ ounce (15 gm) tubes	½ ounce (15 gm) tubes
NDC 0524-0026-51	NDC 0524-0025-51

CAUTION: Federal law prohibits dispensing without a prescription.

TWIN-K®

DESCRIPTION: Each 15 milliliter (tablespoonful) supplies 20 mEq of elemental potassium as a combination of potassium gluconate (15 mEq) and potassium citrate (5 mEq) in a sorbitol base with flavoring.

INDICATIONS AND USAGE: For use as oral potassium therapy in the prevention or treatment of hypokalemia which may occur secondary to diuretic or corticosteroid administration. It may be used in the treatment of cardiac arrhythmias due to digitalis intoxication.

CONTRAINDICATIONS: Severe renal impairment with oliguria or azotemia, untreated Addison's disease, adynamia episodica hereditaria, acute dehydration, heat cramps and hyperkalemia from any cause. This product should not be used in patients receiving aldosterone antagonists or triamterene.

WARNINGS: TWIN-K (potassium gluconate and potassium citrate) is a palatable form of oral potassium replacement. It appears that little if any potassium gluconate-citrate penetrates as far as the jejunum or ileum where enteric coated potassium chloride lesions have been noted. Excessive, undiluted doses of TWIN-K may cause a saline laxative effect.

To minimize gastrointestinal irritation it is recommended that TWIN-K be taken with meals or diluted with water or fruit juice. A tablespoonful (15 ml) in 8 ounces of water is approximately isotonic. More than a single tablespoonful should not be taken without prior dilution.

PRECAUTIONS: Potassium is a major intracellular cation which plays a significant role in body physiology. The serum level of potassium is normally 3.8 – 5.0 mEq/liter. While the serum or plasma level is a poor indicator of total body stores, a plasma or serum level below 3.5 mEq/liter is considered to be indicative of hypokalemia.

The most common cause of hypokalemia is excessive loss of potassium in the urine. However, hypokalemia can also occur with vomiting, gastric drainage and diarrhea.

Usually a potassium deficiency can be corrected by oral administration of potassium supplements. With normal kidney function it is difficult to produce potassium intoxication by oral administration. However, potassium supplements must be administered with caution since usually the exact amount of the deficiency is not accurately known. Checks on the patient's clinical status and periodic E.K.G. and/or serum potassium levels should be made. High serum potassium levels may cause death by cardiac depression, arrhythmias or arrest.

In patients with hypokalemia who also have alkalosis and a chloride deficiency (hypokalemic hypochloremic alkalosis), there will be a requirement for chloride ions. TWIN-K is not recommended for use in these patients.

ADVERSE REACTIONS: Symptoms of potassium intoxication include paresthesias of the extremities, flacid paralysis, listlessness, mental confusion, weakness and heaviness of the legs, fall in blood pressure, cardiac arrhythmias and heart block. Hyperkalemia may exhibit the following electrocardiographic abnormalities: disappearance of the P wave, widening and slurring of the QRS complex, changes of the ST segment and tall peaked T waves.

TWIN-K taken on an empty stomach in undiluted doses larger than 30 ml can produce gastric irritation with nausea, vomiting, diarrhea, and abdominal discomfort.

OVERDOSAGE: The administration of oral potassium supplements to persons with normal kidney function rarely causes serious hyperkalemia. However, if the renal excretory function is impaired potentially fatal hyperkalemia can result. It is important to note that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration with E.K.G. changes.

Treatment measures include:

1. Elimination of potassium containing drugs or foods.
2. Intravenous administration of 300 to 500 ml/hr of a 10% dextrose solution containing 10 – 20 units of crystalline insulin per 1000 milliliters.
3. Correction of acidosis.
4. Use of exchange resins or peritoneal dialysis.

In treating hyperkalemia it should be noted that patients stabilized on digitalis can develop digitalis toxicity when the serum potassium concentration is changed too rapidly.

DOSAGE AND ADMINISTRATION: The usual adult dosage is one tablespoonful (15 ml) in 6-8 fluid ounces of water or fruit juice, two to four times a day. This will supply 40 to 80 ml elemental potassium. The usual preventative dose of potass 20 mEq per day while therapeutic doses range from 30 ml 100 mEq per day. Because of the potential for gastrointe irritation, undiluted large single doses (30 ml or more) or TW are to be avoided.

Deviations from this schedule may be indicated, since no ave total daily dose can be defined, but must be governed by observation for clinical effects.

HOW SUPPLIED: Pint bottles. NDC 0524-0021-16

CAUTION: Federal law prohibits dispensing without a pres tion.

SU-TON®

DESCRIPTION: Forty-five ml of SU-TON contains the fol ingredients:

Pentylenetetrazol	
Niacin	
Vitamin B-1	
Vitamin B-2	
Vitamin B-6	
Vitamin B-12	
Choline	1
Inositol	
Manganese (as Manganese Sulfate)	
Magnesium (as Magnesium Sulfate)	
Zinc (as Zinc Sulfate)	
Iron (as Ferric Pyrophosphate, Soluble)	
Alcohol	

INDICATIONS AND USAGE: SU-TON contains pentylenetet which may be helpful in the older patient as an analeptic when mental confusion and memory defects are present SU also contains vitamins, trace minerals, and iron, for those pa who may benefit by preventing the development of a defici

CONTRAINDICATIONS: Epilepsy, convulsive disorders or h history of sensitivity to any of the listed active ingredients

WARNINGS: The safety of this preparation during pregnanc lactation has not been established. Use of this drug require the physician evaluate the potential benefits of the drug a any possible hazard to the mother and child.

PRECAUTIONS: Although there are no absolute contrai tions to pentylenetetrazol, it should be used with caut epileptic patients or those known to have a low con threshold or a focal brain lesion. Caution should be exe when treating patients with high doses of SU-TON who have disease. While pentylenetetrazol does not act directly o myocardium, the results from central vagal stimulation cause bradycardia.

ADVERSE REACTIONS: Pentylenetetrazol in high dose produce toxic symptoms typical of central nervous s stimulants, which act on the higher motor centers and the cord. Convulsions resulting from this drug are spontaneou are not induced by external stimuli. They usually last for s minutes and are followed by profound depressio respiratory paralysis. Death has been reported from the ing of 10 grams of pentylenetetrazol.

DRUG ABUSE: Drug dependence has not been reporte SU-TON.

OVERDOSAGE: Signs and symptoms of acute overdose m due principally from overstimulation of the central ne system and from excessive vasodilatation with res autonomic nervous system imbalance. The symptoms may i the following: vomiting, agitation, tremors, hyperreflexia, ing, confusion, hallucinations, headache, hyperp tachycardia. Treatment consists of appropriate supp measures. If signs and symptoms are not too severe a patient is conscious, gastric evacuation may be accomplis induction of emesis or gastric lavage.

Intensive care must be provided to maintain adequate tion and respiratory exchange.

DOSAGE AND ADMINISTRATION: One tablespoonful (1 times a day 20-30 minutes before meals. This drug is not f children under 12 years of age.

HOW SUPPLIED:

Bottles of 473 ml (16 fl oz) NDC 0524-0

CAUTION: Federal law prohibits dispensing without a pr tion.

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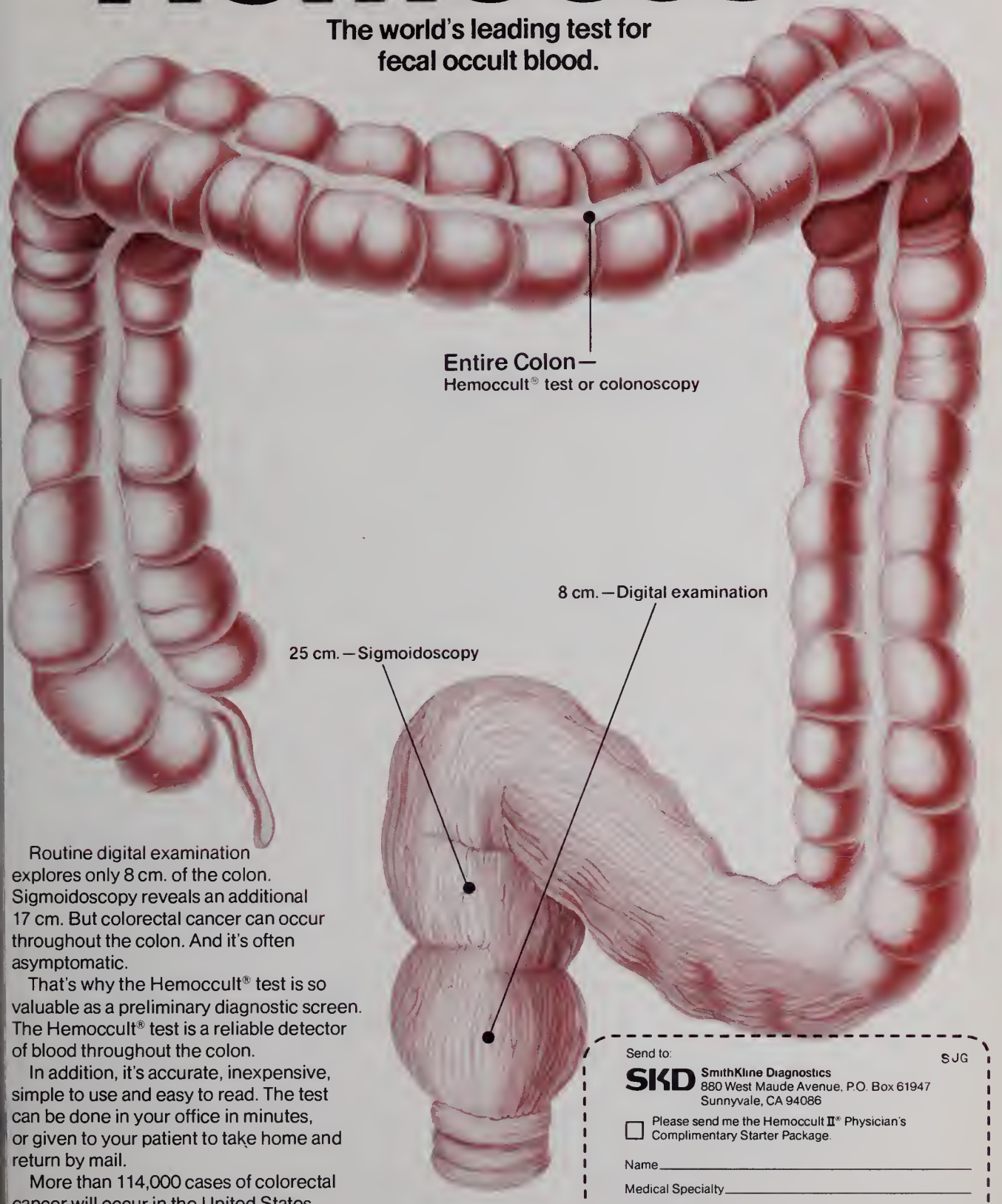
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Hemoccult®

The world's leading test for fecal occult blood.



Routine digital examination explores only 8 cm. of the colon. Sigmoidoscopy reveals an additional 17 cm. But colorectal cancer can occur throughout the colon. And it's often asymptomatic.

That's why the Hemoccult® test is so valuable as a preliminary diagnostic screen. The Hemoccult® test is a reliable detector of blood throughout the colon.

In addition, it's accurate, inexpensive, simple to use and easy to read. The test can be done in your office in minutes, or given to your patient to take home and return by mail.

More than 114,000 cases of colorectal cancer will occur in the United States this year. The earlier they are diagnosed, the greater the chances for successful treatment. Send for your free Hemoccult® starter package, today.

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SKD SmithKline Diagnostics
880 West Maude Avenue, P.O. Box 61947
Sunnyvale, CA 94086

☐ Please send me the Hemoccult II® Physician's Complimentary Starter Package.

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Medical Specialty_____

Address_____

City_____ State_____ Zip_____

Phone_____

Hemoccult® is available through local distributors, nationwide.

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Perdiem

empties the bowel gently...

by filling it.

Perdiem™ . . . the re-educative laxativ
. . . relieves constipation by a unique combination
physiological bulk stimulus and gentle pharmacolog
encouragement of peristaltic response

ROER
RORER
WILLIAM H. RORER, IN
Fort Washington, PA 19034

luggishness of
he Bowels

onstipation

hronic
onstipation

abituation to
axatives

buse of
axatives



Made in West Germany
(Please see next page for prescribing information)

Perdiem™

Prescribing Information

ACTIONS Perdiem™ with its gentle action, does not produce disagreeable side effects. The vegetable mucilages of Perdiem™ soften the stool and provide pain-free evacuation of the bowel. Perdiem™ is effective as an aid to elimination for the hemorrhoid or fissure patient prior to and following surgery.

COMPOSITION. Natural vegetable derivatives: A unique blend of psyllium and senna (Plantago Hydrocolloid with Cassia Pod Concentrate).

INDICATION. For relief of constipation.

PATIENT WARNING: Should not be used in the presence of undiagnosed abdominal pain. Frequent or prolonged use without the direction of a physician is not recommended. Such use may lead to laxative dependence.

DIRECTIONS FOR USE—ADULTS: Before breakfast and after the evening meal, one to two rounded teaspoonfuls of Perdiem™ granules should be placed in the mouth and swallowed with a full glass of warm or cold beverage. Perdiem™ granules should not be chewed. After Perdiem™ takes effect (usually after 24 hours, but possibly not before 36-48 hours), reduce the morning and evening doses to one rounded teaspoonful. Subsequent doses should be adjusted after adequate laxation is obtained.

IN OBSTINATE CASES: Perdiem™ may be taken more frequently, up to two rounded teaspoonfuls every six hours.

FOR PATIENTS HABITUATED TO STRONG PURGATIVES: Two rounded teaspoonfuls of Perdiem™ in the morning and evening may be required along with half the usual dose of the purgative being used. The purgative should be discontinued as soon as possible and the dosage of Perdiem™ granules reduced when and if bowel tone shows lessened laxative dependence.

FOR COLOSTOMY PATIENTS: To ensure formed stools, give one to two rounded teaspoonfuls of Perdiem™ in the evening with warm liquid.

DURING PREGNANCY: Give one to two rounded teaspoonfuls each evening.

FOR CLINICAL REGULATION: For patients confined to bed, for those of inactive habits, and in the presence of cardiovascular disease where straining must be avoided, one rounded teaspoonful of Perdiem™ taken once or twice daily will provide regular bowel habits. Take with a full glass of water or beverage.

FOR CHILDREN: From age 7—11 years, give one rounded teaspoonful one to two times daily. From age 12 and older, give adult dosage.

NOTE: It is extremely important that Perdiem™ should be taken with a plentiful supply of liquid.

HOW SUPPLIED: Granules: 100 gram (3.5 oz) and 250 gram (8.8 oz) canisters.

ROER

WILLIAM H. RORER, INC.
Fort Washington, PA 19034

Not Only Seasons Change

Needs change. Lifestyles change. Sometimes opportunities don't meet expectations. Perhaps your professional environment no longer provides the challenge that's right for you. Or perhaps you and your family may be longing for an environment conducive to your free-time interests.

Times, places, opportunities change. We're specialists in change. Medseca consultant/placement specialists make a habit of matching the right physician with the right opportunity—be it a private or an Emergency Medicine practice. We can help you with your change. Talk to us now—in confidence—without cost, without obligation.

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MEDSECO

WHEN ANXIETY AND TENSION MAGNIFY PAIN

N MUSCULOSKELETAL DISEASE*



A non-narcotic one-two punch against pain, with concurrent relief of anxiety/tension

EQUAGESIC® ℂ

meprobamate and ethoheptazine citrate with aspirin) Wyeth

OUAGESIC—Abbreviated Summary

***INDICATIONS:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows.

"Possibly" effective for the treatment of pain accompanied by tension and/or anxiety in patients with musculoskeletal disease or tension headache

Final classification of the less-than-effective indications requires further investigation.

The effectiveness of Equagesic in long-term use, i.e. more than four months, has not been assessed by systematic clinical studies. The physician should periodically reassess usefulness of the drug for the individual patient.

ONTRAINDICATIONS: Equagesic should not be given to dividuals with a history of sensitivity or severe intolerance aspirin, meprobamate, or ethoheptazine citrate

ARNINGS: Careful supervision of dose and amounts prescribed for patients is advised, especially with those patients th known propensity for taking excessive quantities of drugs. xcessive and prolonged use in susceptible persons, e g , coholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on or habituation to the drug Where excessive dosage has continued r weeks or months, dosage should be reduced gradually ther than abruptly stopped, since withdrawal of a "crutch" ay precipitate withdrawal reaction of greater proportions an that for which the drug was originally prescribed Abrupt scontinuance of doses in excess of the recommended dose is resulted in some cases in the occurrence of epileptiform izures

pecial care should be taken to warn patients taking meprobamate that tolerance to alcohol may be lowered with reduction slowing of reaction time and impairment of judgement nd coordination

AGE IN PREGNANCY AND LACTATION: An increased risk of congenital malformations associated with e use of minor tranquilizers (meprobamate, chlordiazepoxide, and diazepam) during the first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of child-bearing potential may be pregnant at the time of institution of therapy should be considered. Patients should be advised that if they become pregnant during therapy or intend to become pregnant they should communicate with their physicians about the desirability of discontinuing the drug.

Meprobamate passes the placental barrier. It is present both in umbilical-cord blood at or near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breast-feeding patients, the drug's higher concentrations in breast milk as compared to maternal plasma levels should be considered.

Preparations containing aspirin should be kept out of the reach of children Equagesic is not recommended for patients 12 years of age and under

PRECAUTIONS: Should drowsiness, ataxia, or visual disturbance occur, the dose should be reduced If symptoms continue, patients should not operate a motor vehicle or any dangerous machinery

Suicidal attempts with meprobamate have resulted in coma, shock, vasomofor and respiratory collapse, and anuria Very few suicidal attempts were fatal, although some patients ingested very large amounts of the drug (20 to 40 gm) These doses are much greater than recommended The drug should be given cautiously, and in small amounts, to patients who have suicidal tendencies In cases where excessive doses have been taken, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels Hyperventilation has been reported occasionally Any drug remaining in the stomach should be removed and symptomatic treatment given Should respiration become very shallow and slow, CNS stimulants, e g , caffeine, Metrazol, or amphetamine, may be cautiously administered If severe hypotension develops, pressor amines should be used parenterally to restore blood pressure to normal levels

ADVERSE REACTIONS: A small percentage of patients may experience nausea with or without vomiting and epigastric distress. Dizziness occurs rarely when meprobamate and ethoheptazine citrate with aspirin is administered in recommended dosage The meprobamate may cause drowsiness but, as a rule, this disappears as therapy is continued Should drowsiness persist and be associated with ataxia, this symptom can usually be controlled by decreasing the dose, but occasionally it may be desirable to administer central stimulants such as amphetamine or mephentermine sulfate concomitantly to control drowsiness

A clearly related side effect to the administration of meprobamate is the rare occurrence of allergic or idiosyncratic reactions This response develops, as a rule, in patients who have had only 1-4 doses of meprobamate and have not had a previous contact with the drug Previous history of allergy may or may not be related to the incidence of reactions

Mild reactions are characterized by an itchy urticarial or erythematous, maculopapular rash which may be generalized or confined to the groin Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema, and fever have also been reported

More severe cases, observed only very rarely, may also have other allergic responses, including fever, fainting spells, angioneurotic edema bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case), and hyperthermia Treatment should be symptomatic such as administration of epinephrine, antihistamine, and possibly hydrocortisone Meprobamate should be stopped, and reinstitution of therapy should not be attempted

Rare cases have been reported where patients receiving meprobamate suffered from aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia. In nearly every instance reported, other toxic agents known to heve caused these conditions have been associated with meprobamate A few cases of leukopenia during continuous administration of meprobamate are reported, most of these returned to normal without discontinuation of the drug

Impairment of accommodation and visual acuity has been reported rarely

OVERDOSE: Two instances of accidental or intentional significant overdosage with ethoheptazine citrate combined with aspirin have been reported These were accompanied by symptoms of CNS depression, including drowsiness and light-headedness, with uneventful recovery However, on the basis of pharmacological data, it may be anticipated that CNS stimulation could occur Other anticipated symptoms would include nausea and vomiting Appropriate therapy of signs and symptoms as they appear is the only recommendation possible at this time Overdosage with ethoheptazine combined with aspirin would probably produce the usual symptoms and signs of salicylate intoxication Observation and treatment should include induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions

DESCRIPTION: Each Equagesic tablet contains 150 mg meprobamate, 75 mg ethoheptazine citrate and 250 mg aspirin

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*This drug has been evaluated as possibly effective for this indication

Wyeth Laboratories
Philadelphia, Pa 19101

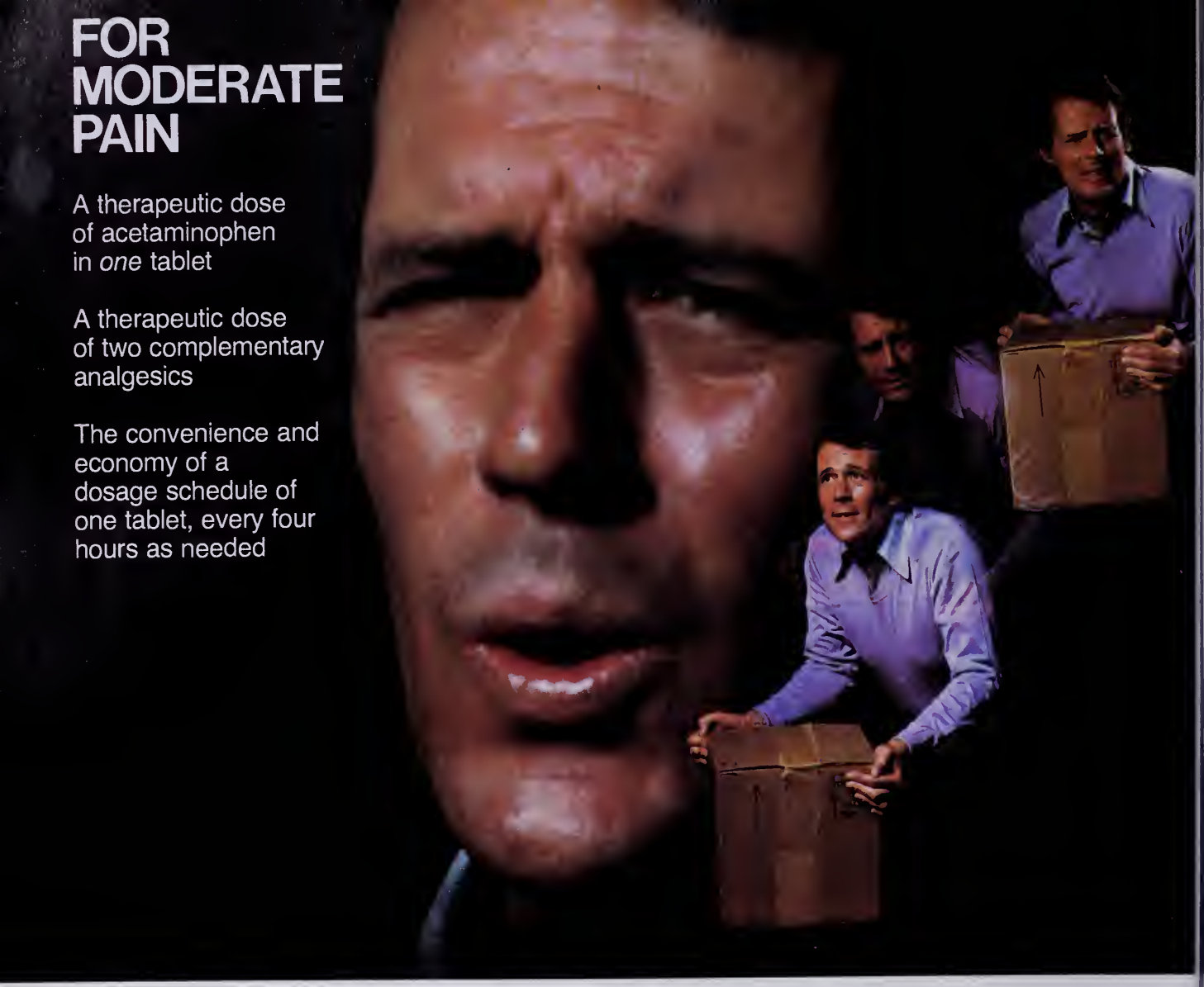
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FOR MODERATE PAIN

A therapeutic dose of acetaminophen in *one* tablet

A therapeutic dose of two complementary analgesics

The convenience and economy of a dosage schedule of one tablet, every four hours as needed



WHY NOT WYGESIC® ℠

(65 mg propoxyphene HCl and 650 mg acetaminophen) Wyeth

WYGESIC—Abbreviated Summary

INDICATION: For the relief of mild-to-moderate pain.

CONTRAINDICATION: Hypersensitivity to propoxyphene or to acetaminophen.

WARNINGS: CNS ADDITIVE EFFECTS AND OVERDOSAGE Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, or other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended Toxic effects and fatalities have occurred following overdoses of propoxyphene alone or in combination with other CNS depressants. Most of these patients had histories of emotional disturbances or suicidal ideation or attempts, as well as misuse of tranquilizers, alcohol, or other CNS-active drugs. Caution should be exercised in prescribing large amounts of propoxyphene for such patients (see **Menagement of Overdosage**).

DRUG DEPENDENCE: Propoxyphene can produce drug dependence characterized by psychic dependence and less frequently, physical dependence and tolerance. It will only partially suppress the withdrawal syndrome in individuals physically dependent on morphine or other narcotics. The abuse liability of propoxyphene is qualitatively similar to codeine's although quantitatively less, and propoxyphene should be prescribed with the same degree of caution appropriate to the use of codeine

USAGE IN AMBULATORY PATIENTS: Propoxyphene may impair the mental and/or physical abilities required for potentially hazardous tasks, e.g. driving a car or operating machinery. Patients should be cautioned accordingly.

USAGE IN PREGNANCY: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. INSTANCES OF WITHDRAWAL SYMPTOMS IN THE NEONATE HAVE BEEN REPORTED FOLLOWING USAGE DURING PREGNANCY Therefore, propoxyphene should not be used in pregnant women unless, in the judgement of the physician, the potential benefits outweigh the possible hazards.

USAGE IN CHILDREN: Propoxyphene is not recommended for children because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric group

PRECAUTIONS: Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine. The CNS depressant effect of propoxyphene may be additive with other CNS depressants, including alcohol.

ADVERSE REACTIONS: The most frequent adverse reactions are dizziness, sedation, nausea, and vomiting These seem more prominent in ambulatory than in nonambulatory patients, some of these reactions may be alleviated if the patient lies down. Other adverse reactions include constipation, abdominal pain, skin rashes, light-headedness, headache, weakness, euphoria, dysphoria, and minor visual disturbances. The chronic ingestion of propoxyphene in doses over 800 mg per day has caused toxic psychoses and convulsions. Cases of liver dysfunction have been reported.

DRUG INTERACTIONS: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, and other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. (see **Wernings**) Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine

MANAGEMENT OF OVERDOSAGE: SYMPTOMS The manifestations of serious overdosage with propoxyphene are similar to those of narcotic overdosage and include respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, pupillary constriction, and circulatory collapse. In addition to these characteristics, which are reversed by narcotic antagonists such as naloxone, there may be other effects. Overdoses of propoxyphene can cause delay of cardiac conduction as well as focal or generalized convulsions, a prominent feature in most cases of severe poisoning. Cardiac arrhythmias and pulmonary edema have occasionally been reported, and apnea, cardiac arrest, and death have occurred.

Symptoms of massive overdosage with acetaminophen may include nausea, vomiting, anorexia, and abdominal pain, beginning shortly after ingestion and lasting for 12 to 24 hours. However, early recognition may be difficult since early symptoms may be mild and nonspecific. Evidence of liver damage is usually delayed. After the initial symptoms, the patient may feel less ill; however, laboratory determinations are likely to show a rapid rise in liver enzymes and bilirubin. In case of serious hepatotoxicity, jaundice, coagulation defects, hypoglycemia, encephalopathy, coma, and death may follow Renal failure due to tubular necrosis, and myocardiopathy, have also been reported.

Ingestion of 10 grams or more of acetaminophen may produce hepatotoxicity A 13-gram dose has reportedly been fatal.

TREATMENT: Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation. The narcotic antagonists, naloxone, nalorphine, and levallorphan, are specific antidotes against the respiratory depression produced by propoxyphene. An appropriate dose of one of these antagonists should be administered, preferably IV, simultaneously with efforts at respiratory resuscitation and the antagonist should be repeated as necessary until the patient's condition remains satisfactory. In addition to a narcotic antagonist, the patient may require careful titration with an anticonvulsant to control seizures. Analeptic drugs (e.g. caffeine or amphetamine) should not be used because of their tendency to precipitate convulsions.

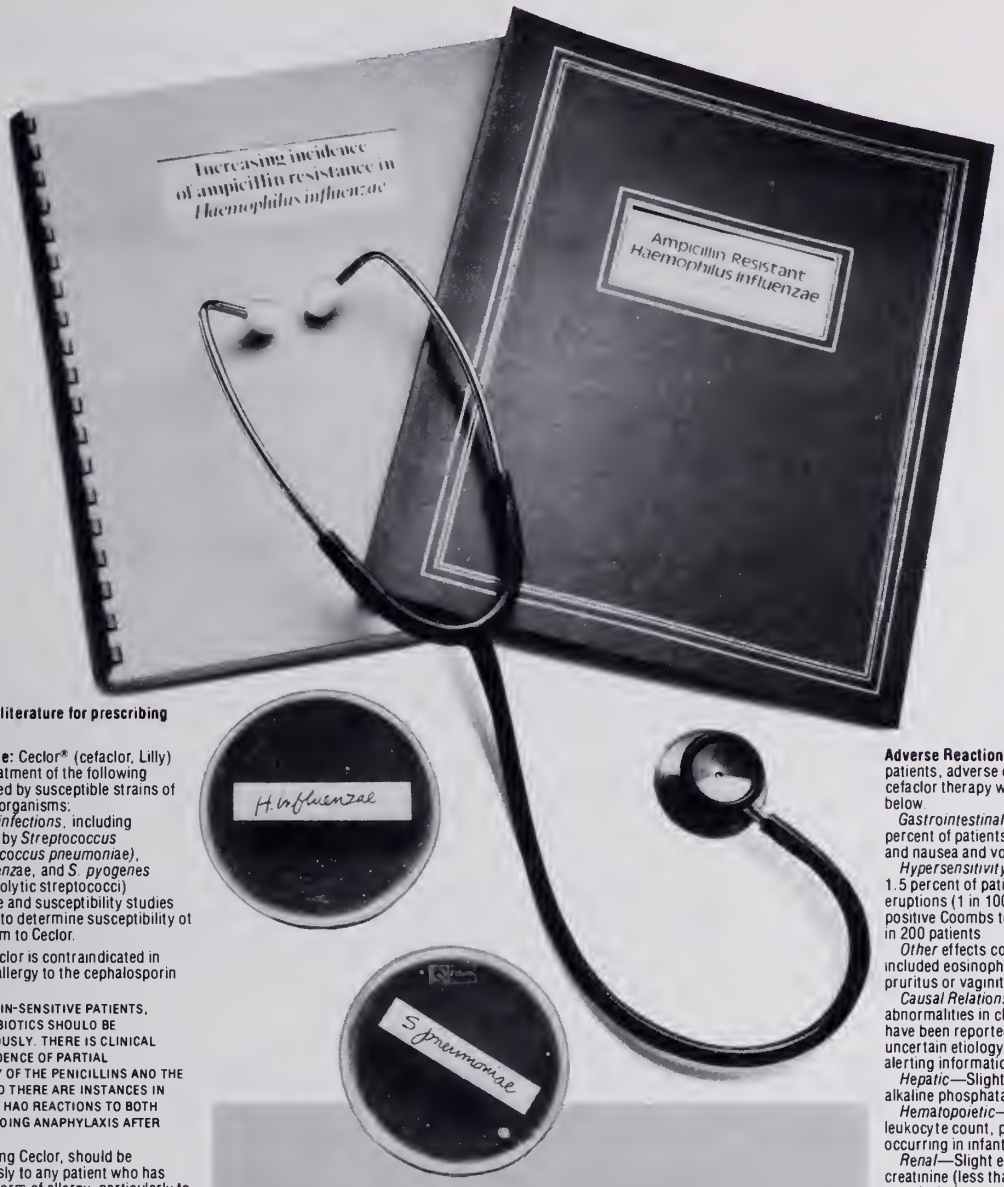
Oxygen, IV fluids, vasopressors and other supportive measures should be used as indicated. Gastric lavage may be helpful. Activated charcoal can absorb a significant amount of ingested propoxyphene. Dialysis is of little value in poisoning by propoxyphene alone. Acetaminophen is rapidly absorbed, and efforts to remove the drug from the body should not be delayed Copious gastric lavage and/or induction of emesis may be indicated. Activated charcoal is probably ineffective unless administered almost immediately after acetaminophen ingestion. Neither forced diuresis nor hemodialysis appears to be effective in removing acetaminophen. Since acetaminophen in overdose may have an antidiuretic effect and may produce renal damage, administration of fluids should be carefully monitored to avoid overload. It has been reported that mercaptamine (cysteamine) or other thiol compounds may protect against liver damage if given soon after overdosage (8-10 hours). N-acetylcysteine is under investigation as a less toxic alternative to mercaptamine, which may cause anorexia, nausea, vomiting, and drowsiness. Appropriate literature should be consulted for further information. (JAMA 237:2406-2407, 1977)

Clinical and laboratory evidence of hepatotoxicity may be delayed up to one week Acetaminophen plasma levels and half-life may be useful in assessing the likelihood of hepatotoxicity. Serial hepatic enzyme determinations are also recommended.

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An added complication... in the treatment of bacterial bronchitis*



Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

Ceclor®
cefaclor
Pulvules®, 250 and 500 mg

Brief Summary.
Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae)*, *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER PARENTERAL USE).

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefaclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

Usage in Pregnancy—Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy—Safety of this product for use in infants less than one month of age has not been established.

Adverse Reactions: In clinical studies in 1493 patients, adverse effects considered related to cefaclor therapy were uncommon and are listed below.

Gastrointestinal symptoms occurred in about 2.5 percent of patients and included diarrhea (1 in 70) and nausea and vomiting (1 in 90).

Hypersensitivity reactions were reported in about 1.5 percent of patients and included morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs tests each occurred in less than 1 in 200 patients.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory tests results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200). [070379R]

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.[8]

Note: Ceclor® (cefaclor) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

References

1. Antimicrob. Agents Chemother., *8*:91, 1975.
2. Antimicrob. Agents Chemother., *11*:470, 1977.
3. Antimicrob. Agents Chemother., *13*:584, 1978.
4. Antimicrob. Agents Chemother., *12*:490, 1977.
5. Current Chemotherapy (edited by W. Siegenthaler and R. Luthy), II: 880. Washington, D.C.: American Society for Microbiology, 1978.
6. Antimicrob. Agents Chemother., *13*:861, 1978.
7. Data on file, Eli Lilly and Company.
8. Principles and Practice of Infectious Diseases (edited by G.L. Mandell, R.G. Douglas, Jr., and J.E. Bennett), p. 487. New York: John Wiley & Sons, 1979.

Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285

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The FMA Office Overhead Expense Plan

You know how important it is to maintain your practice and to keep in touch with patients through your office — when you aren't available because of injury or illness — even if only for a few days. Just imagine the consequences if your disability were prolonged for six months or a year. And if your overhead costs have increased recently from inflation you'll appreciate even more the important protection made available by your medical association.

The Florida Medical Association's Professional Overhead Expense Plan can help you meet your overhead expenses when you are totally disabled. Many fixed expenses are not eliminated when you are unable to practice — rent, employee's salaries, utilities, phones and other costs continue; some even if your office is closed.

The essential yet economical coverage from this plan can provide benefits up to $5,000 monthly for covered office expenses incurred while you're disabled by accident or sickness. And our low tax deductible rates make it practical too.

Choose from two plans:

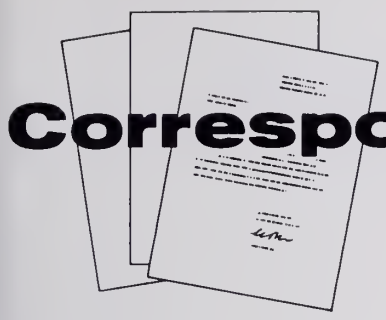
PLAN I — Provides benefits after 15 days of disability

PLAN II — Provides benefits after 30 days of disability

HOUSE OR HOSPITAL CONFINEMENT IS NOT REQUIRED!

For further information concerning the Plan, contact

The Professional Insurance Management Company (PIMCO).



Correspondence

ON MEDICAL MEDIATION PANELS

(Editor's Note: The following letter was received by Richard S. Hodes, M.D., Immediate Past President of the Florida Medical Association following the Florida Supreme Court decision finding Medical Mediation Panels unconstitutional. The Medical Mediation Panel system has proved to be an effective means of reducing nonmeritorious malpractice actions and thus containing professional liability insurance costs. The exchange is presented as a matter of interest to FMA members.)

Richard S. Hodes, M.D.
President
Florida Medical Association

Dear Doctor Hodes: I am in receipt of the March 13, 1980 Memo of the FMA regarding the change in the legal status of the Medical Mediation Panels. Although I was sorry to find that this ruling had become effective, it has always been my personal feeling that the Medical Panels were unconstitutional to start with and, above all, would never serve any useful purpose for doctors.

More importantly, I am extremely concerned that the Florida Physicians Insurance Reciprocal would be so quick to state "...increases in premiums in 1981 are inevitable." I think that this is totally improper and in my personal opinion unnecessary. I have been concerned that the Florida Physicians Reciprocal was planning to branch out into other areas of insurance this past year. I think that they should concern themselves with the job at hand and that is to provide medical malpractice insurance for the Members of the Society at the lowest possible cost.

I hope that the State Society will do everything possible to see that there are no increases in premiums for 1981, and that the Florida Physicians Reciprocal will have to account for all of their expenditures.

Sincerely,
Dr. _____

Dear Dr._____: Your conclusion that the Medical Mediation Panels are unconstitutional on their face demonstrates a remarkable clairvoyance since the Florida Supreme Court could not flatly show that same conclusion. The Court merely determined that certain time restraints in the law rendered the Panels inoperable.

The quick response of the Reciprocal relative to premium increases required considerable less clairvoyance since the reinsurer clearly provides a fixed discount of charges as a credit because of the Mediation Panel law. Should the Reciprocal enter into other lines of business which is not contemplated at the moment, it would only use the generated profits to reduce malpractice premiums. This in lieu of less profitable investments is and when appropriate.

If we are able to enact cost recovery legislation we feel it will help reduce possible increases in premiums. Attitudes such as those expressed in your letter contribute little to the success of such an effort.

Sincerely yours,
Richard S. Hodes, M.D.
President
Florida Medical Association

PHYSICAL FITNESS ISSUE LAUDED

To the Editor: Please send me another copy of the April 1980 Special Issue of *The Journal of the Florida Medical Association* on Physical Fitness. I think it is an excellent issue and I would like to present it to my daughter who is in training.

Vernon H. Bartley, M.D.
Elmhurst, Illinois



Roy H. Behnke, M.D., of Tampa . . . has assumed duties as Florida Regional Governor of the American College of Physicians. **Dr. Behnke,** Professor and Chairman of the Department of Medicine at the University of South Florida College of Medicine, succeeds **Charles K. Donegan, M.D.,** of St. Petersburg, who has held the post for several years.

Meanwhile, the ACP announced that 12 Florida physicians are included in the latest group of Fellows. They are:

Martin Arostegui, M.D., and **Jose S. Bocles, M.D.,** both of Miami; **Richard N. Baney, M.D.,** Melbourne; **Philip G. Boysen, M.D.,** and **William B. Deal, M.D.,** both of Gainesville; and **Seymour S. Feld, M.D.,** Miami Beach.

Alan I. Leibowitz, M.D., and **Gary H. Lyman, M.D.,** both of Tampa; **Lewis H. Kaminester, M.D.,** North Palm Beach; **Raymond L. Parker Jr., M.D.,** Coral Gables; **Brian G. Salisbury, M.D.,** Clearwater; and **Joseph W. Warren, M.D.,** Orlando.

Two more providers . . . of continuing medical education in Florida have been accredited by the American Medical Association through the Florida Medical Association's Committee on Continuing Medical Education.

Boca Raton Community Hospital and the Florida Division, American Cancer Society, each were accredited for two years, according to **Henry M. Yonge, M.D.,** Chairman of the FMA Committee. Accreditation was effective as of March 28, 1980 for the hospital and on April 18 in the case of the Cancer Society.

They were the 14th and 15th institutions and organizations to be accredited by AMA through the FMA since the joint accreditation program was developed several years ago.

An organization accredited for CME is authorized to sponsor or co-sponsor educational activities for AMA Category I Credit.



Dr. Foust

Betty J. Foust, M.D. . . . has been appointed one of three Medical Directors within the Medical Division of Blue Shield of Florida.

She will work under **Richard C. Dever, M.D.,** Vice President for Medical Affairs. A graduate of the Indiana University College of Medicine, Dr. Foust practiced general medicine and allergy in Florida for several years and joined Blue Cross and Blue Shield as a hearing officer in Fort Lauderdale in 1978.

Richard R. Gutekunst, Ph.D....has been named Dean of the College of Health Related Professions at the University of Florida.

For the past five years, Dr. Gutekunst has held a similar position at Hahnemann Medical College in Philadelphia, directing nine associate degree and baccalaureate degree programs enrolling 700 students annually. He will assume duties in Gainesville in July.

Dr. Gutekunst received his doctorate in virology from Cornell University in 1958. He is the author or co-author of more than 40 papers in the areas of virology, bacteriology and infection control.

Book Reviews

Book Review Editor — F. Norman Vickers, M.D.

The Heritage of Aviation Medicine, An Annotated Directory of Early Artifacts by Robert J. Benford, M.D. 122 Pages. Illustrated. Price $4.50. Aerospace Medical Association, Washington, D.C., 1979.

This is an illustrated and annotated catalog of early artifacts associated with aviation medicine. It covers the time period from the late 18th century through World War II.

Although extensively researched and well written, this catalog is probably not for the general practitioner. It enumerates, illustrates and gives the location of numerous items of clothing and equipment worn and used by a long line of aviators and of physicians associated with the physiology of flight and the protection of flyers.

While the descriptions of the items catalogued are not overly technical, the appeal of this compilation is directed primarily concerned, now and in the past, with the problems of protecting the aviator from the dangers and stresses of the dangerous environment in which he must operate.

This directory of historical memorabilia will be fascinating to those in the development of aviation medicine, but will probably be of limited interest to the general practice of medicine.

F. J. Frese Jr., M.D.
Cocoa Beach

Dr. Frese, formerly Director of Bioastronautics, USAF, MC, is retired.

Pharmacological and Toxicology Perspectives of Commonly Abused Drugs by Darryl Inaba, Pharm.D., E. Leong Way, Ph.D., Kenneth Blum, Ph.D., and Sidney H. Schnoll, M.D., Ph.D. 43 Pages. National Drug Abuse Center, Medical Monograph Series, Vol. 1, No. 5 (Jan) 1978.

This medical monograph published by the National Drug Abuse Center is a successful attempt by Drs. Inaba, Way, Blum and Schnoll to review and reinforce fundamental concepts on the pharmacology and toxicology of commonly abused drugs. The monograph starts with a "soul-searching" pre-test on the pharmacology and toxicology of drugs of abuse which may render a reader unfamiliar with the area helpless. However, a one page general introduction and two-page review of principles of pharmacology reassures any reader discouraged by the pre-test.

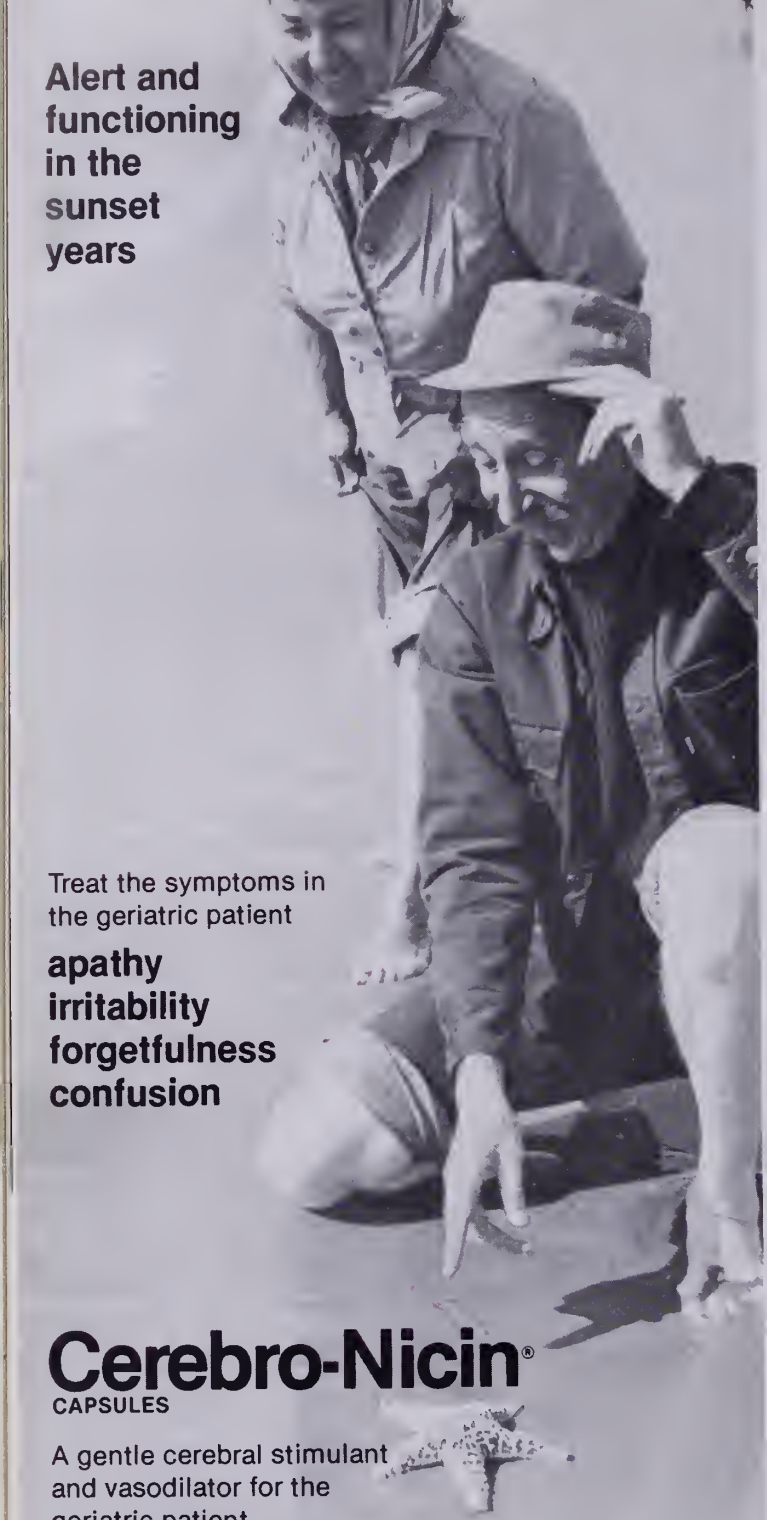
A section of the pharmacological aspects of common drugs of abuse readably reviews the four main groups of drugs of abuse and hallucinogens. The actions and reactions of drugs from each group including several practical considerations are discussed.

A section on street pharmacology and toxicology discusses peculiar problems superimposed on the intrinsic toxicology of drugs of abuse by contaminants and other factors inherent in drugs purchased and taken on the street. The monograph ends with a post test which most readers would feel comfortable with, and for which 4 hours of credit in Category I for the Physicians' Recognition Award of the American Medical Association may be earned.

The monograph is quite appropriate for what it was intended to serve, which is to enable physicians and other members of the health care team to acquire a better understanding of the beneficial and harmful effects of drugs of abuse. Scientists and clinicians involved routinely with the subject matter of drugs of abuse may find the monograph boring and sketchy; however it was not addressed to them.

Peter U. Nwangwu, Pharm.D., Ph.D.
Tallahassee

Dr. Nwangwu is Director of Clinical Research and Assistant Professor of Pharmacology and Toxicology, School of Pharmacy, Florida A&M University.



Cerebro-Nicin®
CAPSULES

A gentle cerebral stimulant and vasodilator for the geriatric patient

Each CEREBRO-NICIN® capsule contains:

Pentylenetetrazole	100 mg.
Nicotinic Acid	100 mg.
Ascorbic Acid	100 mg.
Thiamine HCL	25 mg.
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Niacinamide	5 mg.
Riboflavin	2 mg.
Pyridoxine HCL	3 mg.

AVAILABLE: Bottles 100, 500, 1000

SIDE EFFECTS: Most persons experience a flushing and tingling sensation after taking a higher potency nicotinic acid. As a secondary reaction some will complain of nausea, sweating and abdominal cramps. The reaction is usually transient.

INDICATIONS: As a cerebral stimulant and vasodilator.

RECOMMENDED GERIATRIC DOSAGE: One capsule three times daily adjusted to the individual patient.

WARNING: Overdosage may cause muscle tremor and convulsions.

CONTRAINDICATIONS: Epilepsy or low convulsive threshold.

CAUTION: Federal law prohibits dispensing without prescription. Keep out of reach of children.

Write for literature and samples

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REFER TO PDR

Books Received

Receipt of the following books is acknowledged. Medical readers interested in reviewing particular books are invited to address requests to the Book Review Editor. Following acceptance of a written review for publication, a reviewer may then retain the book reviewed for his personal or favorite library.

The Chemistry of Human Behavior by Herbert L. Meltzer, Ph.D. 261 Pages. Illustrated. Price $17.95 (cloth). Nelson-Hall Publishers, Chicago, 1979.

Annual Review of Neuroscience with 31 contributing authors. 555 Pages. Annual Reviews, Inc., Palo Alto, California, 1979.

The Vitamin Book by Rich Wentzler. 224 Pages. Price $4.95. Doubleday & Company, Inc., New York, 1979.

Cooking Creatively for Your Diabetic Child by Caroline Hastings Babington. 224 Pages. Price $8.95. Doubleday & Company, Inc., New York, 1979.

Clinical Anxiety/Tension in Primary Medicine: Proceedings of a Colloquium, Washington, D.C., Excerpta Medica, Lawrenceville, N.J.

Handbook of Pediatrics by Henry K. Silver, M.D.; C. Henry Kempe, M.D. and Henry B. Bruyn, M.D. 730 Pages. Price $9.50. Lange Medical Publications, Los Altos, California, 1980.

Handbook of Poisoning, Tenth Edition, by Robert H. Dreisback, M.D. 578 Pages. Price $9.50. Lange Medical Publications, Los Altos, California, 1980.

General Ophthalmology, Ninth Edition, by Daniel Vaughan, M.D. and Taylor Asbury. 410 Pages. Price $15.00. Illustrated. Lange Medical Publications, Los Altos, California, 1980.

Controlling the Use of Therapeutic Drugs, An International Comparison, edited by William M. Wardell. 263 Pages. Price $4.75. Illustrated. American Enterprise Institute for Public Policy Research, Washington, D.C., 1978.

Annual Reviews Reprints: Immunology, 1977-1979, compiled by Irving Weissman. 466 pages. Illustrated. Annual Reviews, Palo Alto, California, 1980.

The Diabetic Gourmet, Revised Edition by Angela Bowen, M.D. 193 Pages. Price $10.95. Harper and Row, New York, 1980.

Current Pediatric Diagnosis and Treatment by C. Henry Kempe, M.D., Henry K. Silver, M.D., and Donough O'Brien, M.D. 1122 Pages. Illustrated. Price $20.00. Lange Medical Publications, Los Altos, California, 1980.

A Psychiatric Glossary, Fifth Edition. 142 Pages. Price $5.95. American Psychiatric Association, Washington, D.C., 1980.

What's Your Diagnosis

Editor's Note: In keeping with *The Journal's* interest in continuing medical education, we are beginning a series of interesting medical problems and their surprising diagnoses. This feature is intended to stimulate thought while providing information of practical value. The first case is brought to our attention by William W. Thompson, M.D., of Fort Walton Beach. If you would like to contribute to this series, send a brief resume of your case with the diagnosis to *The Journal* for review and possible publication.

Unexplained Urticaria

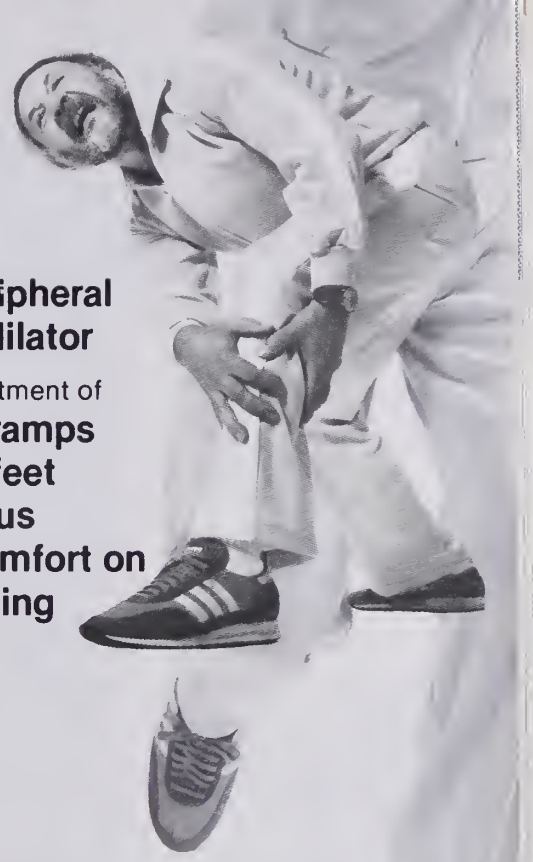
A female patient is undergoing surgery, and the usual intravenous fluid consisting of 5% dextrose in Lactate of Ringer's solution has been introduced into her left hand. Unexplainably, hives develop, starting in the hand and progressing along the course of the vein up the arm. Otherwise, the patient is doing well, and the surgery is proceeding uneventfully. Alarmed by the sudden hives, the surgical tems discontinues the IV, putting in an entirely new line in the opposite upper extremity. Careful observation shows that the urticaria in the left arm disappears, but reappears in the right arm, beginning near the point where the needle was inserted, and proceding up the arm in the general area of the vein.

As surgery progresses, the physicians in attendance seek advice about the inexplicable urticaria, which has now all but disappeared.

What's Your Diagnosis?

In assessing the situation, the consulting physician feels the IV bag and notes that it is cool to touch. He concludes that the patient has cold urticaria, and is responding to the cold IV fluids which are thought to be having a direct action on the mast cells. It is significant that the location of the urticaria corresponds to the course of the cold IV fluids as they are infused in the vein of the extremity. A check with the patient's family verifies that the patient has a past history of cold urticaria, and cannot tolerate cold water or chills without developing hives.

Consequently, it is recommended that in the future the patient will be given IV fluids which have been warmed.



A peripheral vasodilator

for treatment of
leg cramps
cold feet
tinnitus
discomfort on standing

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For patient's
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in choice of
3 strengths

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Nicotinic Acid .....300 mg.
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Riboflavin (B-2) .....2 mg.
Pyridoxine HCL (B-6) .....10 mg.
in a special base of prolonged therapeutic effect.
DOSE: 1 to 2 tablets daily.
AVAILABLE: Bottles of 100, 500.

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Each yellow tablet contains:
Nicotinic Acid .....250 mg.
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Ascorbic Acid .....150 mg.
Thiamine HCL (B-1) .....25 mg.
Riboflavin (B-2) .....2 mg.
Pyridoxine HCL (B-6) .....10 mg.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500.

LIPO-NICIN®/100 mg.

Each blue tablet contains:
Nicotinic Acid .....100 mg.
Niacinamide .....75 mg.
Ascorbic Acid .....150 mg.
Thiamine HCL (B-1) .....25 mg.
Riboflavin (B-2) .....2 mg.
Pyridoxine HCL (B-6) .....10 mg.
DOSE: 1 to 5 tablets daily.
AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN® 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient.

Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur.

Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

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Can you have too much of a good thing?

Too much milk, many pediatricians warn, can fill a child up and consequently, can keep him from eating other foods he needs. Particularly, iron-rich foods.

And, of course, that's a major dietary concern.

But you can also have too little of a good thing. Especially, milk. Milk supplies more essential nutrients per calorie than most other foods.

A child between the ages of six months and six years, for example, can get at least three-fourths of his daily dietary allowance for calcium, riboflavin, vitamins D and B_{12}, phosphorus, and protein from just three glasses of milk. And milk is also a good source of vitamins A and B_6, as well as thiamin and niacin.

That's why the U.S.D.A., acting on the recommendation of the National Research Council—National Academy of Sciences, has established these guidelines for milk consumption:

Children up to 6 years
Two to three 8 oz. glasses per day.

Children 6 to 12 years
Three or more 8 oz. glasses per day.

For a free copy of the Dairy Council Digest issue titled, "Composition and Nutrient Value of Dairy Foods," contact your local Dairy Council or write the National Dairy Council, 6300 North River Road, Rosemont, Illinois 60018.

Per cent of Recommended Daily Allowance contributed by three 8 oz. glasses of fortified milk.

	6 mos.—1 yr.	1 yr.—3 yrs.	3 yrs.—6 yrs.
Calcium	100%	100%	100%
Riboflavin	100	100	100
Vitamin B_{12}	100	100	100
Protein	100	100	80
Phosphorus	100	85	85
Vitamin B_6	76	51	34
Vitamin D	75	75	75
Niacin*	71	63	47
Thiamin	56	40	31
Vitamin A	46	46	37

*maximum niacin equivalents based on: 60 mg tryptophan=1 mg niacin

ndc **National Dairy Council**

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and

THE NORTH FLORIDA REGIONAL MEDICAL FOUNDATION

announce

THE SIXTH CARDIOVASCULAR SYMPOSIUM

September 4 - 5, 1980

The Hilton Inn — Gainesville, Florida

Director: Howard W. Ramsey, M.D.
Co-Directors: Luis J. Cintado, M.D.
Thomas D. Bartley, M.D.

The sixth symposium is devoted primarily to a review and reappraisal of past and current concepts of diagnosis and treatment of cardiac disease. Topics that will be discussed during this year's symposium include: medical and surgical treatment of coronary artery disease, current status of prosthetic cardiac valves, coronary angioplasty, coronary artery spasm, nuclear cardiology and two-dimensional echocardiography.

FACULTY

Philip O. Alderson, M.D.
Richard Conti, M.D.
Donald Effler, M.D.
Larry Elliot, M.D.
Nicholas Fortuin, M.D.
Goffredo Gensini, M.D.
Harold R. Gertner, M.D.
Pierre Brondin, M.D.
J. Willis Hurst, M.D.
George Lindesmith, M.D.
Ferrell McNeely, M.D.
Gerald Pohost, M.D.
Charles Rackley, M.D.
William C. Roberts, M.D.
Earl K. Shirey, M.D.
Mason Sones, M.D.
Simon Stertzer, M.D.
W. Jape Taylor, M.D.
Robert A. Vogel, M.D.

Approval for appropriate credit hours has been requested from the Medical Education Committee of the Florida Medical Foundation, the Florida Academy of Family Physicians, the American Society of Radiologic Technologists and Nuclear Technologists, and the National Society of Pulmonary Technologists.

HOTEL RESERVATIONS: A block of rooms has been reserved at the Hilton Inn for symposium participants and reservations can be made through your local Hilton Inn, the Hilton Reservation Service (toll free number listed in your local telephone directory) or by calling the Gainesville Hilton directly (AC-904) 377-4000.

RESERVATION FEES: $200.00 — All physicians
$ 50.00 — Paramedical personnel (nurses, technicians, etc.)

MAKE CHECKS PAYABLE TO: SIXTH CARDIOVASCULAR SYMPOSIUM
MAIL TO: Howard W. Ramsey, M.D.
1131 N.W. 64th Terrace
Gainesville, Florida 32605

For further information call: Dr. Howard Ramsey or Thelma Lewis (AC-904) 377-8570.

Deaths

Abrams, Benjamin P., North Miami; born 1906; Iowa University, 1930; died 1979.

Brammer, Fred E., Dania; born 1889; University of Cincinnati, 1921; member AMA; died January 1980.

Churney, Otto L., Miami; born 1901; Boston University, 1928; member AMA; died February 26, 1980.

Daly, Thomas E., West Palm Beach; born 1907; University of Pennsylvania, 1936; member AMA; died 1979.

Eanni, Bharti Desai, Miramar; born 1948; Grant Medical College, 1971; died 1979.

Feyer, Horst W., Miami; born 1925; Joannes Guttenberg University, 1950; member AMA; died 1979.

Fiorello, Joseph M., Ft. Lauderdale; born 1922; Jefferson Medical College, 1952; died October 1979.

Galluccio, Joseph R., Coral Gables; born 1907; New York Medical College, 1934; member AMA; died March 12, 1980.

Hunter, Thomas V., Deerfield Beach; born 1925; Albany Medical College, 1954; member AMA; died October 1979.

Thought is the seed of action.

Emerson

Ingram, Marion Ellis, Punta Gorda; born 1922; Medical College of Virginia, 1956; member AMA; died December 23, 1979.

Jones, James Frederick, St. Petersburg; born 1911; Harvard Medical School, 1935; member AMA; died February 1, 1980.

Knight, Wallace A., Boca Raton; born 1926; University of Buffalo, 1957; member AMA; died December 21, 1979.

Mahusay, Desideria T., Arcadia; born 1934; Southwestern University, 1961; member AMA; died 1979.

Marion, Dominic A., Miami; born 1905; University of Louisiana, 1937; member AMA; died January 7, 1979.

Needles, Robert Johnson, St. Petersburg; born 1903; State University of Iowa; member AMA; died November 17, 1979.

Orringer, Harry B., Hollywood; born 1913; University of Pittsburgh, 1938; member AMA; died February 24, 1980.

Phillips, James David, Panama City; born 1925; University of Tennessee College of Medicine, 1947; died February 20, 1980.

Rabbitt, Reginald Owen, St. Petersburg, born 1916; Queens University of Belfast, 1941; member AMA; died February 14, 1980.

Ratnoff, Raymond, Miami Beach; born 1910; New York University, 1936; member AMA; died 1979.

Rojas, Enrique A., Miami; born 1921; University of Havana, 1946; died August 1979.

Ross, Maurice E., Clearwater; born 1905; Marquette University, 1930; member AMA; died April 6, 1979.

Rudolph, Councill C., St. Petersburg; born 1897; Tulane Medical School, 1923; member AMA; died December 29, 1979.

Tuckerman, Jacob B., Gainesville; born 1914; School of Medicine Western Reserve University, 1939; member AMA; died November 26, 1979.

Weiler, Kenneth J., St. Petersburg; born 1900; Northwestern University School of Medicine, 1929; member AMA; died January 19, 1980.

Weiner, Leo, Ft. Lauderdale; born 1912; University of Vienna, 1937; member AMA; died December 18, 1979.



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MEETINGS

Accepted by the FMA Committee on Continuing Medical Education for Mandatory Credit

JULY

Clinical Management of Coronary Disease and Exercise Testing, July 11-13, Orlando Hyatt, Kissimmee. For information: International Medical Education Corp., Division of Postgraduate Education, Dept. 12, 64 Inverness Dr., E., Englewood, Colorado 80112.

Ventricular Arrhythmias, July 14, Citrus Memorial Hospital, Inverness. For information: R. Edward Dodge Jr., M.D., 511 W. Highland Blvd., Inverness 32650.

5th Canadian Summer Workshop in EKG, July 19-22, Edmonton, Alberta, Canada, For information: Henry J. L. Marriott, M.D., Rogers Heart Foundation, St. Anthony's Hospital, St. Petersburg 33705.

Dermatopathology Seminar and Slide Conference, July 26-27, Breaker's Hotel, Palm Beach. For information: C. Fenner McConnell, M.D., 5151 N. 9th Ave., Pensacola 32504.

AUGUST

Fundamental and Clinical Aspects of Internal Medicine, Aug. 1980.*

Recent Advances in Medicine, Aug. 11-12, Orlando Hyatt Hotel, Kissimmee. For information: Emelie H. Ongcapin, M.D., St. Barnabas Medical Center, Dept. of Pathology, Old Short Hills Road, Livingston, New Jersey 07039.

Annual Florida Registry Workshop, Aug. 13-15, Holiday Inn Surfside, Daytona Beach. For information: John Carbonneau, 1001 South Macdill Avenue, Tampa 33609.

EKG Interpretation and Arrhythmia Management, Aug. 22-23, Dutch Inn, Lake Buena Vista. For information: International Medical Education Corp., Division of Postgraduate Education, Dept. 12, 64 Inverness Dr., E., Englewood, Colorado 80112.

18th Annual Seminar in Cardiology, Aug. 30-Sept. 6, Copenhagen, Denmark. For information: Henry J. L. Marriott, M.D., Rogers Heart Foundation. St. Anthony's Hospital, St. Petersburg 33705.

SEPTEMBER

Dermatology in Florida, Sept. 8, Citrus Memorial Hospital, Inverness. For information: R. Edward Dodge Jr., M.D., 511 W. Highland Blvd., Inverness 32650.

Neurology for Neurologists, Sept. 25-27, Palm Beach. For information: Stephen A. Shaivitz, M.D., 3701 Broadway, West Palm Beach 33407.

OCTOBER

Echocardiography In-Service Workshop, Oct. 20-24, University of Miami, Jackson Memorial Medical Center, Miami.*

21st Workshop in EKG for Nurses and Physicians, Oct. 30-Nov. 3, Sheraton Sand Key Hotel, Clearwater Beach. For information: Henry J. L. Mariott, M.D., St. Anthony's Hospital, St. Petersburg 33705.

NOVEMBER

Vascular Lesion of CNS, Nov. 10, Citrus Memorial Hospital, Inverness. For information: R. Edward Dodge Jr., M.D., 511 W. Highland Blvd., Inverness 32650.

Clinical Management of Coronary Disease and Exercise Testing, Nov. 14-16, Orlando Hyatt, Kissimmee. For information: International Medical Education Corp., Division of Postgraduate Education, Dept. 12, 64 Inverness Dr., E., Englewood, Colorado 80112.

JANUARY

Florida Society of Pathologists Annual Slide Seminar, Jan. 1-Feb. 1, Contemporary Building .(Disney World), Lake Buena Vista. For information: C.F. McConnell, M.D., 5151 N. Ninth Ave., Pensacola 32504.

***For information: Contact Division of Continuing Medical Education, D23-3, University of Miami School of Medicine, P.O. Box 016960, Miami 33101. Tel. (305) 547-6716.**

****For information: Contact Division of Continuing Education, Box J-233, J. Hillis Miller Health Center, Gainesville 32610. Tel. (904) 392-3143, or 392-3183.**

+For information: Contact Janifer M. Judisch, M.D., CME, University of South Florida, Tampa 33620. Tel. (813) 974-2196.

CLASSIFIED ADS

Physicians Wanted

FAMILY PRACTITIONER OR INTERNIST wanted to share facilities with three practitioners in solo practice. Major equipment provided. Rent $250 per month. Competent laboratory and x-ray departments with income based on use. Bookkeeping system and receptionist shared. Contact: T.C. Kenaston Jr., M.D., P.O. Box 550, Cocoa, Florida 32922.

EMERGENCY PHYSICIANS for position with young expanding group. Liberal salary package. Send CV to I. Bloomfield, M.D., Medical Director, P.O. Box 160132, Snapper Creek Station, Miami, Florida 33116 or call.(305) 596-2896.

WANTED: Primary care and subspecialty physicians to join multispecialty group in South Palm Beach County. Excellent facilities. Compensation includes possibility of ownership in P.A. Send CV to P.O. Box 23606, Oakland Park, Florida 33334.

PHYSICIAN WANTED: Non-Clinical disability evaluation medical consultation for Social Security. Full-time 40-hour week. Knowledge of electrocardiographic interpretation desirable. Write or call G. M. Davis, Chief Medical Consultant, 3438 Lawton Road, Suite 127, Orlando, Florida 32803. Phone.(305) 896-4691.

TWO MAN OFFICE ON ANNA MARIA ISLAND needs high quality Family Physicians. New building, fully equipped with lab and x-ray. Exceptional opportunity for ownership. Contact E.P. Dickerson, M.D., 2010 59th Street West, Bradenton, Florida 33505, or call collect.(813) 792-2211.

PREPAID HEALTH CARE, INC., a Federally qualified HMO, is recruiting internists, BE or BC, for adult ambulatory care units in Clearwater and St. Petersburg. Excellent salary and benefit programs, with opportunity to participate in academic program available. Progressive, growing community. If interested in growing with us, send CV to Jerry Williamson, M.D., Medical Director, 1417 South Belcher Road, Clearwater, Florida 33516. Phone (813) 535-3474.

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FAMILY PRACTITIONER, Moore Haven, Florida, on Lake Okeechobee, population 1,500. No doctor in county; excellent fishing and hunting. Industries include cattle, farming (sugar cane +), fishing. Call (813) 946-1212 between 9-5 p.m., Monday through Friday.

INTERNIST WITH SPECIALTY TRAINING in Pulmonary or Cardiology to join three doctors in busy North Miami practice. Mail CV to Stanford B. Cooke, M.D., 12570 N.E. 7th Avenue, North Miami, Florida 33161.

WANTED: INTERNIST, Board eligible or certified, to join in association with two other established certified internists in Pompano Beach, Florida. Excellent office and laboratory facilities. Night call and office expenses are shared equally. Reply: Drs. Lewis — Schalk, Suite 104, 1800 North Federal Highway, Pompano Beach, Florida 33062.

SURGEON — GENERAL, Board Certified preferred, Thoracic and Vascular also preferred, to associate with an established Surgeon or have practice arrangement. Location small town suburb of Orlando. Write C-976, Post Office Box 2411, Jacksonville, Florida 32203.

PHYSICIAN FOR CORRECTIONAL INSTITUTION. Family Practice or Internal Medicine specialty preferred. 40 hour work week, good salary. Contact Melvin Gardner, Personnel Officer, Missouri State Penitentiary, 631 State Street, Jefferson City, Missouri 65101 or phone.(314) 751-3224.

FAMILY PHYSICIAN GROUP in beautiful Boca Raton seeking qualified and motivated FP. Guarantee plus percentage with liberal benefits. The ocean, ideal weather, and an exploding population makes area particularly attractive. Send CV, or call James W. McCauley, M.D., 745 Meadows Road, Boca Raton, Florida 33432. (305) 392-0310.

BOARD CERTIFIED OR ELIGIBLE ORTHOPEDIC SURGEON — To join the medical community in the paradise of Florida — Key West. Live and work in an island community of 40,000 permanent residents that share its ideal climate and numerous water sports with another 1¼ million winter residents and tourists each year. Experience the feeling of swimming, scuba diving, water skiing, spear fishing, deep sea fishing and flying all year long. Available hospitals include a 120-bed JCAH hospital and a 34-bed private hospital. Salary potential is excellent. Interested physicians should immediately contact: Joseph J. Scarlet, M.D., Chief of Medical Staff, Florida Keys Memorial Hospital, Post Office Box 2008, 3428 North Roosevelt Boulevard, Key West, Florida 33040. Phone: (305) 296-8579.

INTERNIST OR FAMILY PRACTITIONER to take over a well established Internal Medicine practice in Suncoast Florida. Excellent gross. Equipment and building with doctor tenants included in sale or lease to qualified applicant. Available July or August 1980. Reply C-975, Post Office Box 2411, Jacksonville, Florida 32203.

SURGERY DIRECTOR: Opening for Director of Residency Training Program in Surgery with Pensacola Educational Program, Pensacola, Florida, for Board Certified physician. Total program of 50 residents in six different residencies associated with four different hospitals in community-based educational program. Salary competitive with excellent fringe benefits of paid vacation, liability insurance, health and disability insurance, paid educational and professional trips. Program affiliation with several large medical schools. Gulf Coast living at its best, and health care in immediate area of over ¼ million. Must fill position by July 1, 1980. If interested in teaching and patient care, call collect: Dr. R. D. Nauman, Director of Medical Education,.(904) 477-4956 or send CV to Director of Medical Education, Pensacola Educational Program, 5149 North Ninth Avenue, Suite #307, Pensacola, Florida 32504.

THREE YEAR APPROVED PSYCHIATRIC RESIDENCY PROGRAM now appointing for an immediate unexpected opening and for July 1980. Small intensive psychiatric hospital, JCAH approved, affiliated with University of Iowa Medical College. Comprehensive program including two adult psychiatric units, adolescent unit, childrens unit, alcohol and drug abuse unit, with innovative community liaison and OPD. Eclectic approach. Situated in picturesque northeast Iowa near large cities with cultural advantages, but in rural setting. Ideal for family living. No financial sacrifice while learning. Good salary; liberal fringe benefits; some housing available. Opportunity to join staff upon completion of training. All applicants must have completed one year in an approved training program in internal medicine, family practice, or pediatrics, or a flexible one year program including four months in internal medicine. Write or call R. M. Akbar, M.D., Acting Superintendent, or B. J. Dave, M.D., Director of Education, Mental Health Institute, Independence, Iowa 50644. An Equal Opportunity Employer.

FLORIDA — Immediate opportunity for Board certified or eligible Anesthesiologist. Practice involves M.D. supervision of three hospital employed CRNAs plus personal administration of anesthesia within a progressive 153 bed acute care Central Florida hospital. Emphasis on general surgery, thoracic, vascular, urology, ophthalmology and ENT. Well-equipped department including Ohio-DM 5000 gas machines, Saturn monitors and K-thermia blankets. Multiple recreational, educational and cultural activities closeby. Enjoy the Florida good life! Contact Carl J. Bender, Administrator, Waterman Memorial Hospital, P.O. Drawer B, Eustis, Florida 32726.

UNIVERSITY PHYSICIAN — OB/GYN, for urban University with Medical/Nursing Schools, and excellent fringe benefits. Contact L. E. Stevens, M.D., Director, University of South Florida, Student Health Services, Tampa, Florida 33620. An Equal Opportunity Employer.

FAMILY PRACTITIONER—Board certified or eligible with Florida license to join Internist in South Florida city of 35,000. Send CV to Robert Carraway, M.D., Box 2008F, Key West, Florida 33040.

CARDIOLOGIST, Board certified in Internal Medicine and Board eligible or dertified in Cardiology. Must be experienced in cardiac catherization, echocardiogram (including 2D), pacemaker implants, and stress testing. 40 hour week, excellent salary including medical insurance. Please send your CV to C-985, Post Office Box 2411, Jacksonville, Florida 32203 or call (305) 868-3241 for an interview.

Situations Wanted

UROLOGIST, 31, married, Board eligible, excellently trained at major NYC University Medical Center, available June 1980; desires association, partnership, group or solo practice in Florida. Phone (212) 628-7354.

M.D.: AMERICAN TRAINED, board certified by the American Board of Obstetrics and Gynecology with a Florida license, 42, male, U.S. citizen, interested in buying, joining or associating with another M.D. in the specialty of OB-GYN, preferably on the eastern coast of Florida, population of not less than 40-60,000. Applicant has 10 years experience. For further information contact Mr. Soril at (516) 694-1164 after 7:30 p.m., or write: C-970, Post Office Box 2411, Jacksonville, Florida 32203.

INTERNIST-NEPHROLOGIST finishing nephrology fellowship in large N.Y.C. hospital, seeking to associate with established Internist. Any position considered. Strong clinical experience with the geriatric patient and a fluent command of both Spanish and English. Write or call for C.V. to Lawrence Bress, M.D., Coney Island Hospital, Brooklyn, N.Y. 11235 or phone toll free 1-800-432-7999, ext. 381.

RADIOLOGIST, 30 YEARS CLINICAL PRACTICE in South Florida, completing one year post-doctoral fellowship in abdominal ultrasound and CT imaging, in July 1980 at Johns Hopkins Hospital. Desire salaried position in general hospital including obstetrics in ultrasound and CT scanning in South Florida. Reply to Maurice M. Greenfield, M.D., Department of Radiology and Radiological Science, The Johns Hopkins Hospital, Baltimore, Maryland 21205, or call (301) 955-5811.

OB/GYN — 29-year-old American male, Emory University/Grady trained M.D. wishes to join group practice in coastal Florida. Licensure by reciprocity. Write N. B., 3860 Bretton Woods Road, Decatur, Georgia 30030. Available July 1981.

GENERAL SURGEON, Board Certified, F.A.C.S., F.R.C.S.(C.), 20 years surgery, trauma and industrial practice wishes relocation in 1981 to Florida Gulf Coast. Write all offers to C-973, Post Office Box 2411, Jacksonville, Florida 32203.

SITUATION WANTED: 52 year old Board eligible General Internist (with Florida license) wishes to relocate on the East Coast of Florida.(Fort Lauderdale — West Palm Beach area). After 20 years of solo practice in New York desires association with group of Internists or purchase of practice in Internal Medicine. Phone (516) 665-7414 or write C-963, Post Office Box 2411, Jacksonville, Florida 32203.

BOARD CERTIFIED GENERAL SURGEON trained in Chest, Vascular and Plastic. Florida license. Would like association with another surgeon or surgical group. Age 52, excellent health, available immediately. Write C-978, Post Office Box 2411, Jacksonville, Florida 32203.

RETIRED FAMILY PRACTITIONER, Florida licensed, seeks part-time practice in Hillsborough county. Write C-979, Post Office Box 2411, Jacksonville, Florida 32203.

PATHOLOGIST, Board Certified with 15 years experience in all subspecialties, Florida licensed, seeks hospital association or locum tenens. Write C-980, Post Office Box 2411, Jacksonville, Florida 32203.

INTERNIST / CARDIOLOGIST ABIM Certified, presently in practice wants to relocate. Has Florida license, available immediately. Write C-981, Post Office Box 2411, Jacksonville, Florida 32203.

RADIOLOGIST, EXPERIENCED GENERALIST (no angiography). Part-time position acceptable; relocating in Clearwater/St. Petersburg area. Board certified, Florida licensed. Phone (305) 776-7734, D. Kaighin, 4013 North Ocean Drive, Lauderdale-by-the-Sea, Florida 33308.

PHYSICIAN, 33, certified in Internal Medicine and Diagnostic Radiology, eligible for Gastroenterology, seeks association in Palm Beach County. Available Summer, 1980. Please write Dr. L. Rothenberg, c/o S. Rothenberg, 150T Plymouth, Century Village, West Palm Beach, Florida 33409.

POSITION WANTED: 38 year old Physician Assistant retiring from Air Force October 1, 1980, desires to join rural family practice. Nationally certified, graduated 1976, four years experience in

primary care with some emergency room and in-patient duties. Contact G. M. Cooke, 15600 Warwick Boulevard, Lot 35, Newport News, Virginia 23602. Phone (804) 887-0398.

PHYSICIAN'S ASSISTANT — GENERAL SURGERY: 30 years old, NBME board certified, university AMA approved training, additional one year surgical internship, two years "first assistant" hospital experience. Seeks busy surgical group association or hospital employment. Resume on request: Post Office Box 964, Frazer, Pennsylvania 19355.

GENERAL INTERNIST, University trained, completing residency, board eligible, seeks purchase of established practice or association with practicing internist(s). Prefer Pinellas, Sarasota, Palm Beach, Broward and northern Dade counties. Experienced in exercise testing, some knowledge of echocardiography. Available October 1980. Write C-982, Post Office Box 2411, Jacksonville, Florida 32203.

OB/GYN BOARD ELIGIBLE 34 year old male seeking to buy a practice or associate with Ob/Gyn or Family Practitioner. Reply: Dr. Juan Cavres, 303 East South Street, Bloomfield, Iowa 52537, or call (515) 664-3027 collect.

SITUATION WANTED, SPECIALIST — Trained emergency room physician with over 10 years of experience, Florida licensed, member of ACEP, seeks full time ER work in medium-size hospital. Available with two weeks notice. Prefers group practice. Reply C-983, Post Office Box 2411, Jacksonville, Florida 32203.

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VERY ACTIVE ESTABLISHED OB-GYN PRACTICE FOR SALE. Established Ob-Gyn practice, fully equipped office with personnel. Ideal location between both area hospitals. Office located in Central Florida. Reply to C-984, Post Office Box 2411, Jacksonville, Florida 32203.

Real Estate

OUTSTANDING LOCATION FOR SPECIALISTS: St. Nicholas Medical Center. Central location, off street parking and all utilities furnished (including janitor service). Contact W. G. Allen Jr., Owner-Manager, St. Nicholas Medical Center, 3127 Atlantic Boulevard, Jacksonville, Florida 32207. Phone (904) 398-5500.

LAKELAND, FLORIDA: FOR SALE, 6% down. Air conditioned office for one to three physicians, Main street, 168 x 140 ft.; double parking lots, extra cottage. Dr. L. Polskin, Box 15966, Honolulu, Hawaii 96815.

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JULY 1980 • VOL 67 • NO. 7



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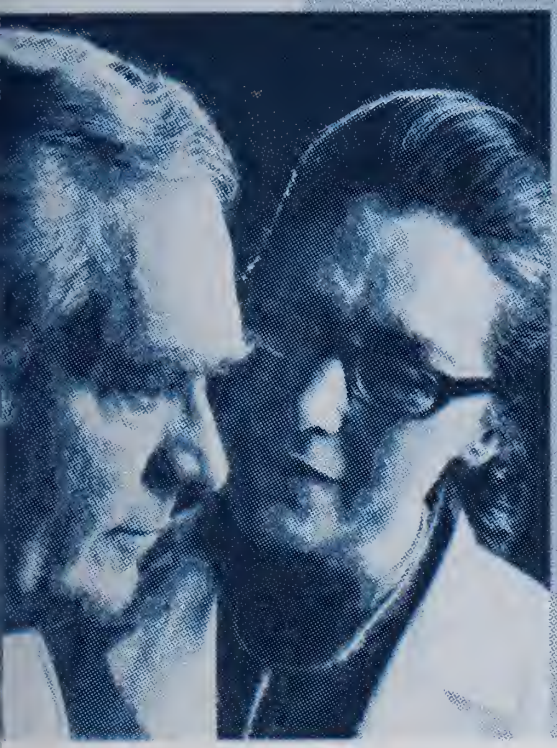
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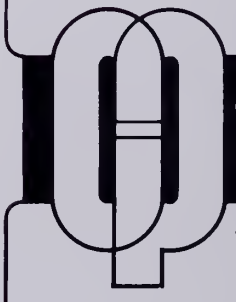
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But let's also make sure children get enough milk. Because milk supplies more essential nutrients per calorie than most other foods.

A child between the ages of six months and six years, for example, can get at least three-fourths of his daily dietary allowance for calcium, riboflavin, vitamins D and B_{12}, phosphorous, and protein from just three glasses of milk. And milk is also a good source of vitamins A and B_6, as well as thiamin and niacin.

That's why the U.S.D.A., acting on the recommendation of the National Research Council—National Academy of Sciences, has established these guidelines for milk consumption:

Children up to 6 years
Two to three 8 oz. glasses per day.

Children 6 to 12 years
Three or more 8 oz. glasses per day.

For a free copy of the Dairy Council Digest issue titled, "Composition and Nutrient Value of Dairy Foods," contact your local Dairy Council or write the National Dairy Council, 6300 North River Road, Rosemont, Illinois 60018.

Per cent of Recommended Daily Allowance contributed by three 8 oz. glasses of fortified milk.

	6 mos.—1 yr.	1 yr.—3 yrs.	3 yrs.—6 yrs.
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Riboflavin	100	100	100
Vitamin B_{12}	100	100	100
Protein	100	100	80
Phosphorus	100	85	85
Vitamin B_6	76	51	34
Vitamin D	75	75	75
Niacin*	71	63	47
Thiamin	56	40	31
Vitamin A	46	46	37

*maximum niacin equivalents based on:
60 mg tryptophan=1 mg niacin

ndc **National Dairy Council**

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JULY 1980 • VOL 67 • NO. 7 (ISSN 0015-4148)

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President's Page

We Are Compelled to Become Involved . . .

On May 29, 1980, the Florida House of Representatives passed the Senate's version of legislation sponsored by the Florida Medical Association to provide for the recovery of costs in civil proceedings. The final bill, which was amended by the Senate to apply only to medical malpractice was allowed to become law by the Governor without his signature on June 5, 1980 and will become effective July 11, 1980. We now have an opportunity through a viable vehicle to see if the threat of paying the cost of a physician's defense when he has been completely vindicated in a medical malpractice suit will serve as a deterrent against frivilous suits. There will, no doubt, be constitutional challenges to the law in the Courts, however, it is hoped that the preamble to the bill will serve to convince judges in future court hearings that the legislation is in fact constitutional.

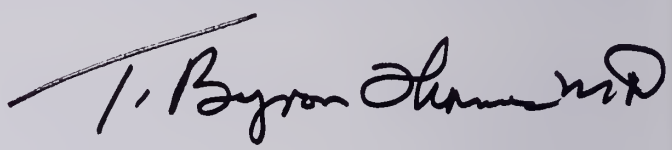
The immensity of the efforts that went into the ultimate success of this bill becoming law are immeasurable. We of the Florida Medical Association are deeply grateful to the legislative leadership and also to the many individual legislators who recognized the seriousness of our plight and the urgency of timely, remedial legislation precipitated by the action of the Florida Supreme Court in declaring the medical mediation panel unconstitutional in February of this year. The gravity of the adverse effect of the Court's ruling on the stability of the professional liability insurance market in Florida cannot be underestimated and the actions of the Legislature surely demonstrated its responsible recognition and concern for this problem and will serve to benefit both physicians and the citizens of Florida. At a minimum, without the law, professional liability insurance rates would increase next year. More dismal is the chilling effect that the Court's ruling had on the future stability of the PLI market and even its availability.

Having faced this PLI challenge and observing the multitude of bills effecting medicine which are introduced during each session of the Legislature makes one conscious of the importance of the individual legislator to the future of the practice of medicine. I am personally convinced that each of us in medicine today are compelled to take a more active part in the political process, including support of candidates whose philosophies are compatible with our own. We individually, and our families, should support candidates of our choice with both our dollars and our participation in their campaigns. There are a number of ways this can be done: through FLAMPAC, individual contributions, and spending time in campaigns soliciting votes for individual candidates. Actually, we **all** need to do **all** of these. Legislators are lobbied by many diverse groups. We need input in the legislative process which can come only if we have the ear and assistance of individual legislators. Apathy deserves no voice so please encourage your spouse and other family members to join you in a more active role in politics. Consider again whether you should become a member of FLAMPAC if you aren't already, and more importantly a sustaining member of FLAMPAC for only $100 per year. In today's political climate we can't afford not to invest this much in our future in medicine.

During the 1980 Session, our staff and legislative lobbyists have followed closely all bills effecting medicine and have kept us informed as to their disposition through numerous FMA publications. Our Council on Legislation and the Committee on State Legislation as well as many individual physicians have worked tirelessly through long days and nights in our behalf and their efforts are greatly appreciated. In addition, I know all of you join me in recognizing the tremendous job done for the FMA by Dick Hodes in his quiet, effective way as speaker pro tem of the House. His keen knowledge of the legislative process, personal acquaintance with the legislators, and effective discussion techniques have served us well in this and many prior sessions of the legislature. We can be proud that he is willing to donate so much of himself and his time to these efforts on behalf of his profession and the citizens of Florida. Also, my personal thanks to our Legislative Council and the Auxiliary and each of you who contacted your legislators on our behalf.

I feel my year as President has begun on an auspicious note and I am confident that with your individual help and that of our colleagues who serve on FMA's Councils and Committees we will be able to accomplish a reasonable reorganization of the FMA structure which will allow us to operate the Association in the most efficient and economical manner possible. We will be reviewing the financial structure of the Association and recommending annually to the House of Delegates an appropriate dues structure. In addition, we will be doing in-depth, long range planning regarding future staff organization for the time when our present EVP retires. We will also be working toward implementation of the Impaired Physicians program and plan to concentrate our efforts in the rehabilitation of valued FMA members who may have become impaired as a result of a dependency on alcohol or other chemical substances in a helpful and non-punitive way.

Please continue to help all of us to make this year a good one for our profession, get involved!



Twenty-Five Years Ago

In *The Journal of the Florida Medical Association* for July 1955:

The scientific section included papers on "Surgery of the Heart and Great Vessels" by **DeWitt C. Daughtry, M.D.**, of Miami, and "ACTH and Cortisone in the Treatment of Pulmonary Infection" by **Louis M. Sales, M.D.**, of Jacksonville . . . FMA President **John D. Milton, M.D.**, of Miami, addressed the annual meeting of the American Pharmaceutical Association at Miami Beach . . . **James H. Ferguson, M.D.**, of New Orleans, became Chairman of the Department of Obstetrics and Gynecology at the University of Miami School of Medicine . . . **O. F. Green, M.D.**, of Mayo, and **Edwin C. Hanson, M.D.**, of Belleview, were honored at separate appreciation day programs sponsored by their communities . . . **Edward R. Annis, M.D.**, a future President of the American Medical Association, addressed the Duval County Visiting Nurses Association in Jacksonville on the subject of "Let's Live a Little Longer" . . . **Lauren M. Sompayrac, M.D.**, of Jacksonville was elected President of the Southeastern Dermatological Association . . .

And so it was in Florida medicine 25 years ago this month. — E.D.H.

Editorial

The Proceedings

As has been customary for the past several years, the July issue of *The Journal* contains the Proceedings of the Annual FMA Meeting. Since *Proceedings* constitute one of the items which the Editor is obligated to publish, I have utilized the occasion to scrutinize FMA Proceedings with respect to background, preparation, cost, and significance. I would hope that the information and commentary based on this analysis would serve not only to incite the reader's interest but also to promote a better understanding and appreciation of the Proceedings section of *The Journal*.

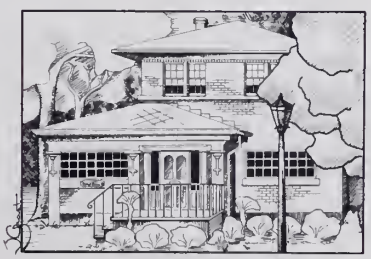
From a historical viewpoint, the *Proceedings* or *Transactions*, as they were formerly called, must be considered an integral part of FMA heritage. Publication of the *Transactions* began following the first Annual Meeting in 1874, thus antedating the inception of the *JFMA* (1914) by 40 years. According to the Oxford Dictionary of English Etymology, *Proceedings* and *Transactions* are interchangeable words when used in the sense of the present text: interestingly enough, however, *Transactions* is the older term (circa 1665 compared to 1830).

The actual business of producing the annual *Proceedings* has become increasingly difficult due to both the growth of the FMA and the expanded number of complex matters requiring attention. Certainly, an inestimable amount of time and effort is contributed by FMA officers and members of the Councils, Reference Committees, and the House of Delegates. In addition, I am told that it takes six full-time staff employees working a total of approximately 100 hours to assemble a finished product. After editorial review and redaction, the *Proceedings* is published at a cost of $5,000.

Any discussion of significance should begin with the basic premise that *Proceedings* represent a permanent record of official business considered and acted upon during the Annual Meeting. A large part of such business involves the disposition of matters affecting medical practice and accordingly, the health of citizens within our State; hence, the content of the *Proceedings* is of the utmost informational value to the entire FMA membership. Publication of the *Proceedings* in the *JFMA* offers the most reasonable and effective means for disseminating this material.

Without question, the *Proceedings* is an extremely worthwhile document; still, it should not be used by the membership as a substitute for attending the Annual Meeting. In this regard, of the 13,000 members of the FMA, an average of only 1,500 physicians have attended each meeting over the past five years. I, therefore, wish to remind the membership that you do not have to be a Delegate to enjoy and benefit from a meeting which provides "something for everybody". Aside from the business of the organization, there are a variety of educational programs; outstanding speakers, medical and non-medical; opportunities to fraternize with colleagues and their spouses; special entertainment; recreational activities; an art show; a selection of nearby fine restaurants and shops; and "just plain fun" for the whole family.

Daniel B. Nunn, M.D.
Editor





William F. Mixson, Jr., M.D. . . . of Coral Gables, has been elected to a three-year term as Secretary of the American College of Obstetricians and Gynecologists. Dr. Mixson has been active in the 22,000-member organization for several years, serving on the Executive Board and holding office as Secretary, Vice Chairman and Chairman of the College's District IV.

A native of Gainesville, the new ACOG Secretary received his M.D. degree in 1948 from Temple University School of Medicine. He served his residency at Temple University Hospital and was certified by the American Board of Obstetrics and Gynecology in 1956.

He is a past president of the Miami, Florida and Southeastern Ob.-Gyn. societies.

J. Robert Cade, M.D., of Gainesville . . . is the 1980 recipient of the Hippocratic Award for Teaching Excellence at the University of Florida College of Medicine. The name of Dr. Cade, Professor of Renal Medicine, will be engraved on a bronze plaque under the tree of Hippocrates on the Shands Teaching Hospital grounds.

Edward W. St. Mary, M.D., of Miami . . . has resigned as Editor of *Miami Medicine*, a post he had held for eight years.

The resignation was effective with the May issue. The Board of Directors of the Dade County Medical Association, the publisher, invited applications from prospective editors and expected to make an appointment prior to publication of the August issue.

Under Dr. St. Mary's leadership, *Miami Medicine* has won awards each year in The Journal of the Florida Medical Association Awards Contest for County Medical Society Bulletins. At the 106th Annual Meeting last May, the publication was given first place in the General Excellence category.

Dr. St. Mary served as an Assistant Editor of *The Journal* from 1976 to 1980.

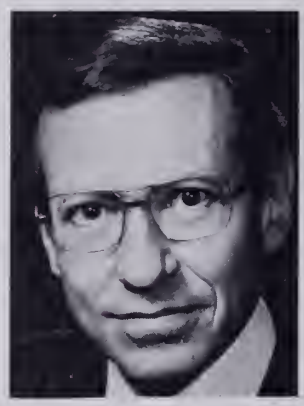
The Diabetes Center . . . at the University of South Florida Medical Center was dedicated on June 7.

Serving an 18- county area, the Center was created as a result of an act of the Florida Legislature several years ago which called for the establishment of such facilities at the State's three medical schools. The Center will be involved with treatment of diabetes and related diseases, as well as research and education.

Ronald A. Arky, M.D., President of the American Diabetic Association and Professor of Medicine at Harvard University, presided at the dedication program.

Brendan O'Malley, M.D., Assistant Professor of Internal Medicine, and **John Malone, M.D.,** Associate Professor of Pediatarics, are Co-Directors of the USF Diabetes Center. By this fall, the staff will number about seven fulltime professionals, including three physicians and a Fellow; a program coordinator and two nurses.

The American Society for Aesthetic Plastic Surgery . . . has installed two Florida surgeons in its top two official positions.



Dr. Kaye



Dr. Baker

Bernard L. Kaye, M.D., of Jacksonville, was installed as President of the Society at its 13th Annual Meeting in Orlando. Elevated to the office of President-Elect was **Thomas J. Baker, M.D.,** Assistant Professor of Plastic Surgery at the University of Miami School of Medicine, Miami.

Dr. Kaye succeeded **Thomas D. Rees, M.D.,** of New York City in the presidency. The new President is a graduate of Harvard School of Dental Medicine and Harvard Medical School. He is a Past President of the Florida Society of Plastic and Reconstructive Surgeons, and is chief of his service at Jacksonville's Baptist Medical Center.

Dr. Baker is a graduate of the Indiana University School of Medicine, and is a former member of the faculty of the University of Missouri School of Medicine.

The primary beneficiaries of ORAL HYDERGINE®

TABLETS, 1 mg (1 tab t.i.d.)

Each 1 mg Hydergine tablet contains dihydroergocornine mesylate 0.333 mg, dihydroergocristine mesylate 0.333 mg, and dihydroergocryptine (dihydro-alpha-ergocryptine and dihydro-beta-ergocryptine in the proportion of 2:1) mesylate 0.333 mg, representing a total of 1 mg.

They're in their late sixties, the beneficiaries of more liberal retirement laws and more enlightened attitudes toward the elderly. They're leading socially productive lives. But recently, without any clear cause, they had each begun to experience mild episodes of symptoms such as confusion, mood-depression, and dizziness. Their ability to function could have been jeopardized. That's when they became the beneficiaries of oral Hydergine therapy.



The still-functioning geriatric can benefit from Hydergine treatment

It is quite common for cognitive and emotional symptoms of deterioration to manifest gradually in the elderly. During this early stage, such symptoms are mild and more amenable to treatment. It is at this stage that Hydergine therapy has proved most effective. Patients tend to respond better, and with symptoms effectively relieved—or at least their progression retarded—the ability to function can be maintained.

Oral Hydergine tablets promote better patient compliance

Compared with the sublingual form, dosage administration is easier, with less need for supervision.

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Contraindications: Hypersensitivity to the drug.
Precautions: *Because the target symptoms are of unknown etiology, careful diagnosis should be attempted before prescribing Hydergine tablets and sublingual tablets.*
Adverse Reactions: Serious side effects have not been found. Some sublingual irritation, transient nausea, and gastric disturbances have been reported. Hydergine tablets and sublingual tablets do not possess the vasoconstrictor properties of natural ergot alkaloids.
Dosage and Administration: 1 mg three times daily. Alleviation of symptoms is usually gradual and results may not be observed for 3–4 weeks.
How Supplied: Hydergine tablets (for oral use) 1 mg, packages of 100 and 500. **Hydergine sublingual tablets 1 mg,** containing dihydroergocornine mesylate 0.333 mg, dihydroergocristine mesylate 0.333 mg, and dihydroergocryptine (dihydro-alpha-ergocryptine and dihydro-beta-ergocryptine in the proportion of 2:1) mesylate 0.333 mg, representing a total of 1 mg; packages of 100, 500, and 1000. **Hydergine sublingual tablets 0.5 mg,** containing dihydroergocornine mesylate 0.167 mg, dihydroergocristine mesylate 0.167 mg, and dihydroergocryptine (dihydro-alpha-ergocryptine and dihydro-beta-ergocryptine in the proportion of 2:1) mesylate 0.167 mg, representing a total of 0.5 mg; packages of 100 and 1000.
Before prescribing, see package insert for full product information.

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FROM THE EDITOR'S DESK

INDIANA MEDICAL MALPRACTICE ACT RULED CONSTITUTIONAL

The Indiana Medical Malpractice Act, one of the first in the nation, was ruled constitutional by the State Supreme Court. Under the law, which has been used by other states in drafting professional liability acts, physicians' premiums support a malpractice fund administered by the state. There is a $500,000 limit on awards, and the liability of physicians who qualify under the act is limited to $100,000.

FLORIDA PHYSICIANS NOMINATED TO AMA COUNCILS

Among those nominated to serve on AMA Councils are two Florida physicians. Their names will be submitted to the House of Delegates by the Board of Trustees at the AMA Annual Meeting this month. Nominated to serve on the Council on Constitution and Bylaws is Charlotte H. Kerr, M.D., of Seminole; while Henry D. McIntosh, M.D., of Lakeland, has been nominated to serve on the Council on Scientific Affairs.

HEALTH AND HUMAN SERVICES DEPARTMENT BUDGET $226 BILLION

Eliminating the education activities of the Health and Human Services Department, the budget for the new department is $226 billion, the third largest for a government entity anywhere in the world. The department's spending will be surpassed only by the governments of the United States and the Soviet Union.

PHS PLANNING ACTIVITIES MOVED

The health planning activities of the Public Health Service will be moved to the Health Care Financing Administration, according to reports of a major reorganization of the Health and Human Services Department. The move, expected to be announced soon, will remove planning activities from the Health Resources Administration.

CLAMPDOWN ON HOSPITAL CONSTRUCTION PROPOSED

A clampdown on all hospital construction and renovation is about to be ordered by President Carter, according to reports received by American Medical News. The Administration contends there are too many beds in 196 of the nation's 213 health service areas (HSAs), and therefore almost $1 billion of building planned for federal hospitals may be cancelled. The impact on non-government hospital construction would be even greater. The proposal has been in the works for months -- since Congress refused to enact the Administration's hospital cost containment bill, which included a limit on capital spending.

FEDERAL SPENDING CUTS MIGHT SHORTCHANGE AMERICANS

Some Federal spending cuts proposed by the President might compromise the health of the American people and could lead to increased expenditures in the future, according to AMA testimony before the House Appropriations Subcommittee. Among the areas which would be severely cut in the Administration's fiscal year 1981 budget would be the National Institutes of Health, medical schools and students, Maternal and Child Health Program, PSRO Program, Food and Drug Administration, nurse training, family planning, disease prevention formula grants, health incentive grants and alcohol, drug abuse and mental health state formula grants.

1981 AMA DUES WILL REMAIN THE SAME

The AMA Board of Trustees has voted not to seek a dues increase at the Annual Meeting of the House of Delegates in July. The last dues increase was approved in 1975, and at that time it was speculated that another increase would be probable in 1981. However, fiscal and performance controls as well as efforts to increase revenues from sources other than dues have been successful. The current AMA dues, in effect since January 1, 1976, are $250.00 annually for regular members, $35.00 for interns and residents, and $15.00 for students.

FEDERAL AID FOR COMMUNITY MENTAL HEALTH CENTERS APPROVED

A three-year extension and revision of the Mental Health Systems Act, which authorizes federal aid for community mental health centers has been approved by the House Commerce Subcommittee on Health. Amendments to the bill (HR 7299) provide that a center's medical services to individual patients be under the direction and supervision of a physician, and that the physician be a psychiatrist whenever possible; and provides that Public Health Service physicians and other health professionals receive the same pay increase as military physicians.

The Editor

Physicians Wanted

Situations Wanted

Practices Available

Equipment

Real Estate

If you are in search of a qualified partner or associate . . . want to relocate . . . buy or sell equipment, real estate, etc., why not consider a classified advertisement in *The Journal of the Florida Medical Association?* Our ads help you reach the right people.

The Journal of the Florida Medical Association

Tenuate® Ⓒ℞
(diethylpropion hydrochloride NF)

Tenuate Dospan®
(diethylpropion hydrochloride NF) controlled-release

AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.

CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).

WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. *Drug Dependence.* Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. *Use in Pregnancy:* Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children:* Tenuate is not recommended for use in children under 12 years of age.

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

ADVERSE REACTIONS: *Cardiovascular:* Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System:* Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal:* Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic:* Urticaria, rash, ecchymosis, erythema, *Endocrine:* impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System:* Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous:* A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in midevening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in midmorning. Tenuate is not recommended for use in children under 12 years of age.

OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

Product Information as of April, 1976

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Cayey, Puerto Rico 00633

Direct Medical Inquiries to:
MERRELL-NATIONAL LABORATORIES
Division of Richardson-Merrell Inc.
Cincinnati, Ohio 45215, U.S.A.

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References: 1. Citations available on request from Medical Research Department, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M.T., O'Dillon [Dillon], R.H., and Leyland, H.M.. A comprehensive review of diethylpropion hydrochloride. In, Central Mechanisms of Anorectic Drugs, S. Garattini and R. Samanin, Ed., New York, Raven Press, 1978, pp. 391-404.

Merrell

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Overweight may not always be simple... complications can develop*.
Complicated or not...

Tenuate® Dospan® ℂ℣
(diethylpropion hydrochloride NF)
75 mg. controlled-release tablets



A useful short-term adjunct in an indicated weight loss program.

Overweight patients in certain diagnostic categories often require strict appetite control and a successful program of weight reduction may tend to diminish the incidence or severity of the complications in some patients. Diethylpropion hydrochloride has been reported useful in such patients and while it is not suggested that Tenuate itself in any way reduces the complications of overweight, it may have a useful place as a short-term adjunct in a prescribed dietary regimen. **Tenuate should not be administered to patients with severe hypertension; see additional Warnings and Precautions on the opposite page.**

In uncomplicated overweight.

Many patients, on the other hand, present with excess fat but no disease. While this condition is often termed uncomplicated obesity, complications of both a social and a psychologic nature may be distressingly real for the patients. In these cases, a short-term regimen of Tenuate can help reinforce your dietary counsel during the important early weeks of an indicated weight loss program.

Clinical effectiveness.

The anorectic effectiveness of diethylpropion hydrochloride is well documented. No less than 16 separate double-blind, placebo-controlled studies attest to its usefulness in daily practice.[1] And the unique chemistry of Tenuate provides "...anorectic potency with minimal overt central nervous system or cardiovascular stimulation."[2] Compared with the amphetamines, diethylpropion has minimal potential for abuse.

Tenuate—it makes sense. And it's responsible medicine.

*Studies have shown that obesity is associated with an increased incidence of hypertension, symptomatic heart disease, adult-onset diabetes, and other diseases.

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For prescribing information see opposite page

In G.I. therapy



Adjunctive Librax®

Each capsule contains
5 mg chlordiazepoxide HCl
and 2.5 mg clidinium Br

antianxiety/antisecretory/antispasmodic

for adjunctive therapy of duodenal ulcer* and irritable bowel syndrome*

Librax®

Please consult complete prescribing information, a summary of which follows:

* **Indications:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:
"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.
Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma, prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl/Roche) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated, avoidable in most cases by proper dosage adjustment but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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Summary of the FMA Board of Governors Meeting June 21, 1980

The following is a summary of the actions taken by the Board of Governors at its meeting on June 21, 1980.

FUTURE MEETING DATES

The Board approved the proposed 1980-1981 meeting dates for FMA meetings, and in addition, directed that the Annual Meeting be moved from the Diplomat Hotel in Hollywood, Florida to the Sheraton Twin Towers in Orlando at the earliest possible date and that all available sites be investigated for future annual meetings.

AMA Annual Meeting	Chicago Marriott	July 20-24, 1980
FMA Executive Committee	Williamsburg, Virginia	October 22, 1980
FMA Board of Governors	Williamsburg, Virginia	October 23-25, 1980
AMA Interim Session	San Francisco	December 7-10, 1980
FMA Executive Committee	Tampa	January 16, 1981
FMA Board of Governors	Tampa	January 17-18, 1981
AMA Winter Scientific Session	Atlanta	January 24-27, 1981
FMA Leadership Conference	Lake Buena Vista	Jan. 31-Feb. 1, 1981
AMA Leadership Conference	Chicago Marriott	February 12-15, 1981
FMA Executive Committee	Tampa	March 13, 1981
FMA Board of Governors	Tampa	March 14-15, 1981
FMA Annual Meeting	Diplomat Hotel	April 29-May 3, 1981
FMA Board of Governors	Diplomat Hotel	May 3, 1981
FMA Executive Committee	Jacksonville	June 19, 1981
FMA Board of Governors	Jacksonville	June 20-21, 1981
AMA Annual Meeting	Chicago Marriott	July 7-11, 1981
FMA Executive Committee	TBA	October 7, 1981
FMA Board of Governors	TBA	October 8-11, 1981
AMA Interim Session	Las Vegas	December 6-9, 1981

The Board also approved changes, where possible, for future annual meeting dates to avoid conflicting with Mother's Day.

FMA Annual Meeting	May 5-9, 1982
FMA Annual Meeting	May 4-8, 1983
*FMA Annual Meeting	May 2-6, 1984
FMA Annual Meeting	May 1-5, 1985
*FMA Annual Meeting	May 14-18, 1986
*FMA Annual Meeting	May 13-17, 1987
*FMA Annual Meeting	May 11-15, 1988

*new dates to avoid conflicting with Mother's Day

HOUSE OF DELEGATES RATIO

Approved the ratio for determining delegates for the 1981 House of Delegates remain at one for every fifty active members of the Association within each County Medical Society, and one for any fraction over and above the last complete unit of fifty.

ANNUAL MEETING THEME

Approved the 1981 Annual Meeting theme as one of "Stress and Life Style" and suggested that the Editor of *The Journal* may wish to consider having a special issue on this theme.

FMA PRIORITIES

Approved FMA priorities for 1980-1981 as follows:

Membership

— Communication with FMA membership directly and through respective county medical and specialty societies.

— Implementation of a statewide impaired physicians program to be phased in as funds and personnel become available. (Through the Florida Medical Foundation)

Public

— Continue to provide government bodies and the public through public

relations programs and speakers bureau, press releases, etc. with prompt and responsive Association views on:

A. Matters relating to public health, mechanisms and standards of health care services and delivery including HSAs, HMOs, etc.
B. Cost of medical care with special emphasis on what organized medicine is doing to stabilize and reduce cost and on the role government plays in escalating costs.

Programs

— Restructure of FMA councils and committees and scope of activities to best serve the interest of the membership.
— Continued implementation of FMA medical services programs with special emphasis on drug abuse, emergency medical services and school health.
— Continued emphasis on local support for legislative activities and development of active political education programs in cooperation with the FMA Auxiliary in each community.
— Educational programs and activities on stress with special emphasis on life style.
— Continued emphasis on a statewide P.M.U.R. program, conducted by the private sector, as a viable alternative to Federal Government controlled programs whose emphasis is solely on cost without regard to quality.
— Continued support for development and marketing of a Medical Encounter Data System (Solution Systems) for physicians and the Florida Health Data Corporation.
— Continued support of the FMA Auxiliary's educational programs in the community.

Issues

— Cost of medical care
— Continued monitoring of the effectiveness of the Department of HRS as it pertains to the public's health and continued strong support for insuring effective medical physician leadership at all levels of the Department.
— Opposition to any compulsory comprehensive national health insurance program.
— Health regulatory activities involving interference in practice of medicine.
— Professional liability
— Strongly support the availability of quality health care for all people.
— Strongly oppose government subsidized programs, agencies and systems that are costly, restrictive and unfairly interfere with the private practice of medicine and with the quality and availability of health care.
— Opposition to encroachment on the practice of medicine by non-M.D. health care providers.

HOUSE OF DELEGATES ACTIONS AND REFERRALS

The Board reviewed a number of actions and resolutions considered by the House of Delegates in May which were referred to the Board of Governors for implementation or future consideration.

Report A — Special Committee on Finance

ACTION OF THE HOUSE

That the House of Delegates authorize the Board of Governors to rigidly limit and curtail the scope of activities of the Association, its councils and committees within the organization's stated objectives in order to insure fiscal integrity through 1980-1981. Special emphasis should be given to those activities which directly affect the membership of the Association.

The Board approved:

— Restructuring of FMA councils and committees to provide for more efficient and coordinated activities to best represent the needs and interests of the FMA membership.
— FMA Council Chairmen for 1980-1981 include:

Council on Legislation
Louis C. Murray, M.D., Chm., Orlando.
Francis C. Coleman, M.D., Vice-Chm., Tampa.

Council on Health Care Financing
Wm. W. Thompson, M.D., Chm., Ft. Walton Beach.

Council on Medical Services
Joseph T. Ostroski, M.D., Chm., Miami.

Council on Scientific Activities
Yank D. Coble, M.D., Chm., Jacksonville.

Council on Specialty Medicine
Dick L. Van Eldik, M.D., Chm., Lake Worth.

Judicial Council
James A. Winslow, Jr., M.D., Chm., Tampa.

— Authorized continued staff and administrative support for the Florida Medical Foundation, FLAMPAC, Florida Physicians Association and the FMA Auxiliary.
— Approved continued support for Solution Systems, Inc. and the Florida Health Data Corporation.
— Directed management to exert every effort to eliminate all administrative activities not directly needed for support of the current priorities and programs of the Association.

ACTION OF THE HOUSE

Directed that the Board of Governors implement such a reorganization plan as necessary to accomplish this objective and report back to the House of Delegates in 1981 with definite recommendations regarding the financing of the Association for future years.

This will be completed by the Ad Hoc Committee on Finance for presentation to the Executive Committee and Board of Governors in preparation of the budget for 1981.

ACTION OF THE HOUSE

Directed that the Executive Committee (through the Board of Governors) annually present to the House of Delegates not only a complete report of the financial status of the Association, but a recommendation regarding the amount of dues necessary for the upcoming year in order to maintain the Association's financial stability and integrity.

This will be considered by the Executive Committee and Board of Governors in January of 1981.

ACTION OF THE HOUSE

The House of Delegates authorized the Board to establish a special Trust Fund for the current and future reserves of the Association, the initial funding coming from the approximately $600,000 profit from the sale of the headquarters building in Jacksonville. The Trustees of this fund might be the last five living past-presidents and perhaps consideration should be given to the addition of one or two lay financial advisors. The Trustees would release income and other funds to the Association only when it became absolutely necessary for a matter of great importance to the Florida Medical Association and upon request of the Board of Governors. The use of such funds should be contemplated only when an emergency existed that could not be financed through the regular income and assets of the Association.

The Board approved:

— Establishment of a special trust fund for current and future reserves of the Association, the initial funds to come from the profits on the sale of the building at 801 Riverside Avenue after purchasing the building located at 760 Riverside Avenue as provided for in the lease purchase option with the Florida Physicians' Insurance Reciprocal.
— That the Trustees of these funds be the three (3) immediate living past presidents of the Association, excluding the immediate past president who is an officer.
— That the principal and interest of these funds accrue in this trust account which shall be established in the name of the Association in an escrow trust. The Trustees may release the funds upon request of the Board of Governors which indicates that an emergency exists which cannot be financed through regular income or assets of the Association. In the event the Trustees do not agree to release the funds, the Board of Governors may direct their release upon ¾ vote of the active members of the Board of Governors.
— That the Trustees of this fund shall elect their own Chairman and other officers as required.

Impaired Physicians Program

ACTION OF THE HOUSE

The House approved the establishment of a statewide Impaired Physician Program and referred this to the Board of Governors for implementation at such time as the Board is of the opinion that A) appropriate legal and statutory provisions exist to protect the confidentiality of records, and B) adequate funding is available for implementation and that progress on the development of this important program be reported by the Board to the House of Delegates at its next meeting.

The Board directed:

— That an Impaired Physicians Program be established by the Florida Medical Foundation.
  1. That the program be phased in as funds and personnel become available.
  2. Subject to the legal clarification regarding confidentiality and liability.

— That the Committee on Impaired Physicians be nominated by the President of the FMA and approved by the Board of Governors of the FMA as a standing committee of the Florida Medical Foundation.
— That the FMA make an annual grant to the Foundation to be utilized for this program, the 1980 grant being approximately $25,000.
— That the FMF solicit the membership of the FMA and Auxiliary for donations and contributions to this fund.
— That the program be initiated with a part time consultant.
— That appropriate liability insurance be obtained.
— Reiterate that all employees and consultants must be approved by the Board of Directors of the Florida Medical Foundation.

Report C — Drug Abuse Committee

ACTION OF THE HOUSE

That consideration be given to the re-establishment of the Committee on Drug Abuse and that this be referred to the Board of Governors for consideration.

The Board directed that a Committee on Drug Abuse be re-established under the Council on Medical Services.

Report D — Continuing Medical Education Records

ACTION OF THE HOUSE

That Resolution No. 80-7 and Resolution 80-8 be referred to the Board of Governors for further consideration.

Resolution 80-7

RESOLVED, That the Resolution 77-19 on Centralized Computer Continuing Medical Education Records adopted by the House of Delegates at the Florida Medical Association Annual Meeting in 1977 be rescinded; and further be it

RESOLVED, That record keeping of Continuing Medical Education with eventual transfer of records to the Florida Medical Association be continued at the local County Medical Society level, because experience demonstrates its effectiveness.

Resolution 80-8

RESOLVED, That the accounting and reporting of continuing medical education credits not be centrally computerized, and be it further

RESOLVED, That continuing medical education accounting and reporting be left to the local societies.

The Board reviewed the history of the CME program including requirements, reporting methods, various policies of the Association, and the expenditure of funds, and directed that:

- The primary responsibility for recording, maintaining and approving CME credits remain with the individual physician's county medical society.
- That the county medical societies report to the FMA at the appropriate reporting time for its members that the individual physician has complied with the CME requirements of the Florida Medical Association. (This may be done at the time of the transmission of the physician's FMA dues)
- The FMA be utilized primarily for matters of appeal when there is a disagreement between the physician and the county medical society or a case of hardship.
- That the Committee on CME be advised that this action does not forego the future possibility of a centralized system for administering the CME program.

Resolution 80-14 State Health Plan

ACTION OF THE HOUSE

The House of Delegates referred this resolution to the Board of Governors for further consideration.

Resolution 80-14

RESOLVED, That each year the Florida Medical Association through its specialty societies and expertise will develop a State Health Plan of its own, for all agencies throughout the state to have immediately available for reference, study and planning purposes.

The Board:

- Referred Resolution 80-14, FMA State Health Plan, to the Committee on HSA's and the Council on Specialty Medicine for further study and consideration of the most effective manner for the FMA to evaluate the State Health Plan utilizing specialty groups and making possible alternate recommendations.

The Board also directed that the FMA seek the opportunity for providing input into the State Health Plan as it is being developed rather than after the fact.

Definition of "Responsible Supervision"

Referred the proposed definition of "Responsible Supervision" to SBME Representative on the Board of Governors for review and recommendations.

Standardized Archives and Application Form

Requested the Executive Director to consult with the Executive Directors of County Medical Societies to determine the societies' current position regarding the desirability of a Standardized Archives and Application Form.

Resolution 80-2 — Museum for Medical History

Requested the Vice President to review Resolution 80-2 regarding establishment of a Museum for Medical History and report back to the Board of Governors with recommendations.

Resolution 80-10 — Osteopathy

Referred Resolution 80-10 to the Speaker of the House to consult with the Broward County Medical Society to clarify the purpose of the Resolution.

Abuse of Class II Drugs

Referred the entire subject of abuse of Class II drugs to the Committee on Drug Abuse for review and recommendations.

Resolution 80-9 — Medicare — Physicians Fees

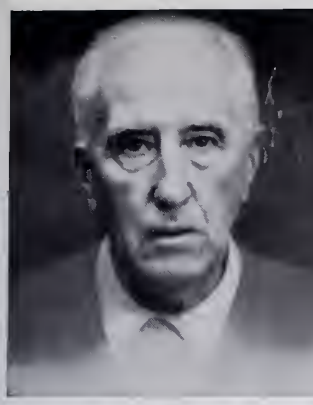
Requested the President to send a letter to Blue Cross, Blue Shield, G.H.I., and all appropriate government agencies reiterating the position of the FMA regarding this subject.

AMA Jail Project

Authorized the Florida Medical Foundation to continue participation in the AMA Jail Project for conducting an evaluation of health care in selected Florida jails for an additional year.

FMA Travel

Authorized FMA sponsorship of medical seminar travel proposals for 1981 to include the Ireland/British Isles Adventure, July, 1981, and the Western Mediterranean Air/Sea Cruise, October, 1981, and to invite the FMA Auxiliary to sponsor one of the trips of their choice.



Dual-action therapy to enhance mental and physical activity in the elderly.

MENIC™

PENTYLENETETRAZOL 100 mg • NICOTINIC ACID 50 mg

Menic combines the proven effectiveness of cortical stimulation and cerebral vasodilation, reducing mental confusion, faulty memory and negative social behavior often associated with the senility syndrome.

DOSAGE: Two tablets after each meal.

SIDE EFFECTS: Occasionally flushing and pruritus associated with niacin administration.

PRECAUTIONS: Use with caution in patients with low convulsive threshold, focal brain lesions, severely impaired liver function, peptic ulcer, diabetes, and gall bladder or liver diseases. Niacin may potentiate hypotensive drugs, phenothiazine derivatives and inactivate fibrinolysin.

CONTRAINDICATIONS: There are no known contraindications to Menic.

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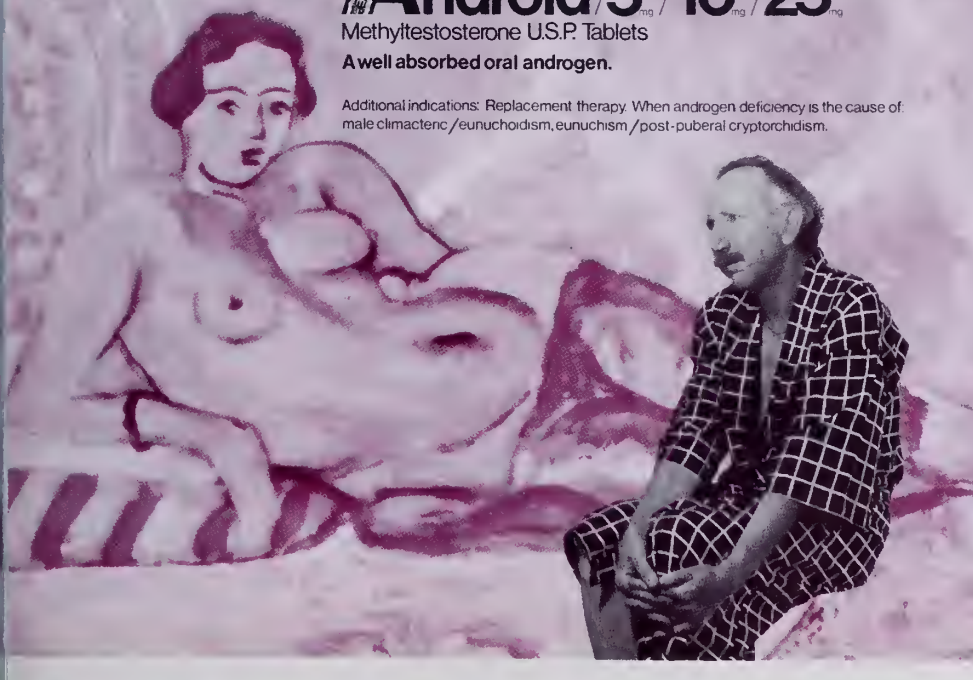
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is due to androgenic deficiency.

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A well absorbed oral androgen.

Additional indications: Replacement therapy. When androgen deficiency is the cause of: male climacteric/eunuchoidism, eunuchism/post-puberal cryptorchidism.



DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administretion or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexuel development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercelcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomasha. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg., Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblett, M.D., R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climecteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only

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Professional Liability Legal Update

Medicaid Fraud Law Unconstitutional

This case involved the constitutionality of a Hawaiian Medicaid Fraud Law. Act 105 of the 1978 Hawaiian Session Laws established a Medicaid Fraud Unit under the Attorney General for the investigation and prosecution of Medicaid fraud. Section 6 of Act 105 requires that each Medicaid provider maintain for a period of three years "such records as are necessary to disclose fully the type and extent of health care, service, or supplies provided to Medicaid recipients". Section 6 further requires that providers make such records available upon request to authorized representatives of the Attorney General's office and makes willful refusal to make records available a misdemeanor. Section 8 authorizes the issuance of warrants to inspect, copy, and maintain records required to be kept under Section 6. Act 105 also requires confidentiality of providers' records.

On December 18, 1978 an administrative inspection warrant was issued authorizing the search and seizure of plaintiff Virgil Willis Jr.'s records relating to Medicaid beneficiaries, including therapeutic notes, patient history forms, medical records and reports, and diagnoses. The affidavit in support of the warrant stated that Willis was a licensed, clinical psychologist and a Medicaid provider, that his offices had never been inspected pursuant to Section 8, and that such inspection was in the public interest. No showing was made as to any particularized need to inspect Willis' records. Further, Willis was never requested, pursuant to Section 6, to produce voluntarily the information described in the warrant. On December 28, 1978 the warrant was executed at Willis' office, records were seized, and copies were made of those records.

On March 7, 1979 Willis and plaintiff Hawaii Psychiatric Society filed an action challenging the constitutionality of the Medicaid Fraud Law. The Hawaii Psychiatric Society, a district branch of the American Psychiatric Association, is a nonprofit corporation composed of 115 psychiatrists, a majority of whom are Medicaid providers. Defendants are all officials of the State of Hawaii authorized to implement Section 8 and are sued in their official capacity.

This case raises issues concerning the right of privacy inherent in the psychotherapist-patient relationship and the reasonableness of administrative searches of psychiatrists' offices. In addition to challenging the law as a violation of their own right to privacy, the Court allowed the plaintiffs to raise privacy rights of their present and future Medicaid patients because it was felt that enforcement of Section 8 will materially affect the rights of Medicaid beneficiaries who have no effective way of asserting those rights in a manner that would prevent their violation. It is the psychiatrists who have the opportunity, as well as the incentive, to assert the privacy rights of the patients by challenging the administrative warrant provisions of Section 8, and the court, therefore, permitted them to do so.

Although the Constitution does not explicitly mention any right of privacy, the Supreme Court has recognized that one aspect of the "liberty" protected by the Due Process Clause of the Fourteenth Amendment is a right of personal privacy or a guarantee of certain areas or zones of privacy. The content of the constitutional right of privacy remains largely undefined; but it was recognized that the Supreme Court has identified at least two strands of the web of privacy: One is the individual interest in avoiding disclosure of personal matters and another is the interest in independence in making certain kinds of important decisions. The administrative inspection scheme at issue in this case implicates both strands of analysis.

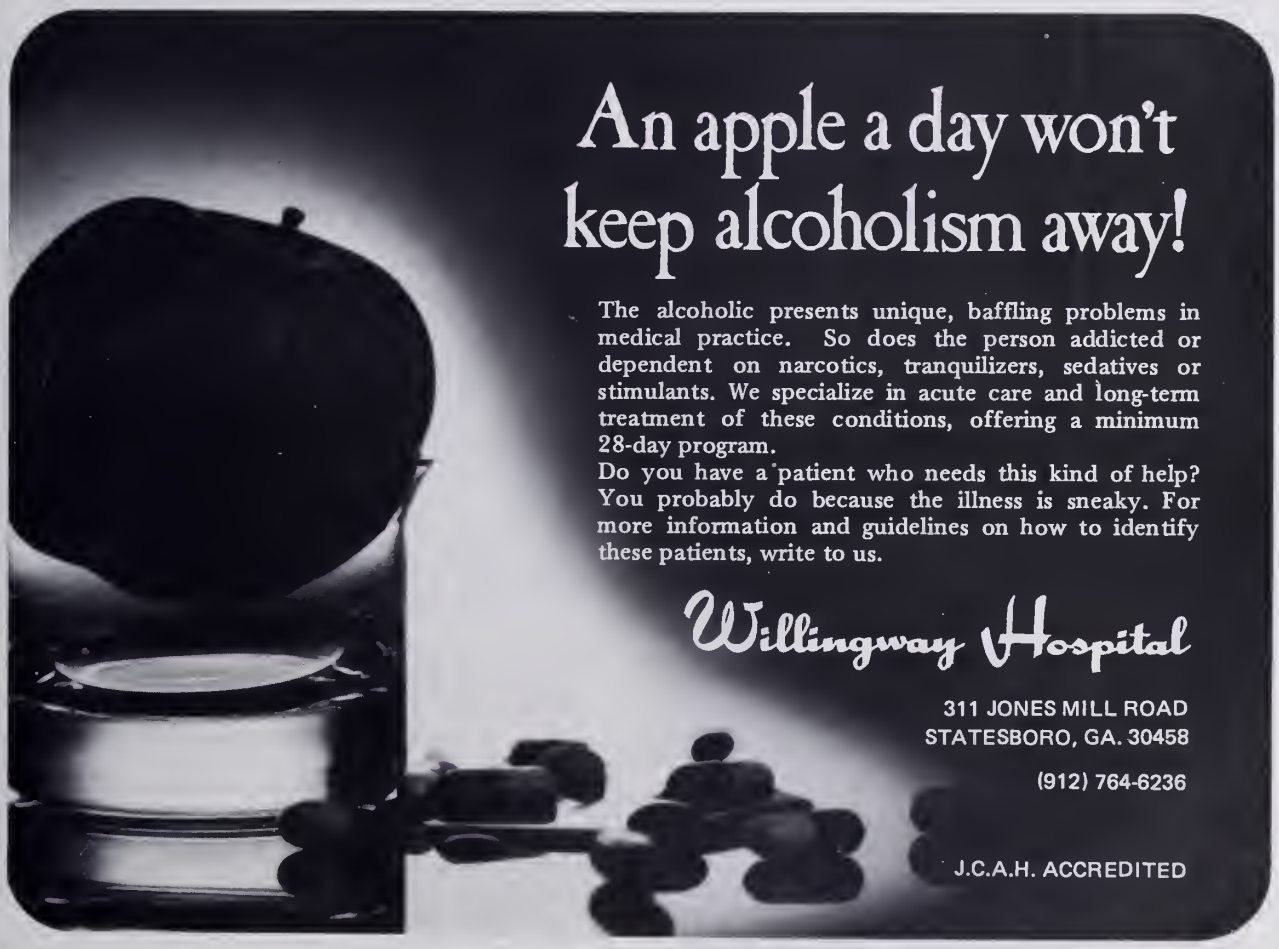
As to the interest in independent decision making, the Court held that the constitutionally protected right of privacy extends to an individual's liberty to make decisions regarding psychiatric care without unjustified governmental interference. That the right of privacy extends to decisions regarding psychiatric care does not, however, automatically render Section 8 invalid. Psychi-

Prepared and submitted by John E. Thrasher, J.D., Vice President and Legal Counsel, and Anthony J. McNicholas III, J.D., Associate Legal Counsel, Professional Insurance Management Co. (PIMCO), Jacksonville, Florida.

atric care may be regulated in ways that do not infringe upon protected individual choices, and even a burdensome regulation may be validated by a sufficiently compelling state interest. The Court's inquiry, therefore, concerned whether Section 8 burdens the individual's liberty to make decisions regarding psychiatric care and, if so, whether the State had demonstrated that the statute represents the least restrictive means to achieve compelling state interests.

The Court conceded that the State has a compelling interest in insuring that services and supplies for which it is being billed have been provided and that the Medicaid Program is not being defrauded. But it was observed that Section 8 was not narrowly drafted to express only those State interests. There had been no showing, and the court did not believe that there could be a showing, that the issuance of warrants to search and seize the therapeutic notes, patient history forms, diagnoses, and other confidential medical records of a psychiatrist, absent even a suspicion that an individual provider has defrauded the State or failed to maintain records, is necessary to serve any of the State interests put forward. Thus, the Court concluded that the Law represented an unlawful intrusion into a patient's constitutionally protected right to make decisions regarding psychiatric care.

As to the second strand of the right to privacy, the individual interest in avoiding disclosure of personal matters, the Court held that the appropriate test calls for a balancing of the state interests served by a regulation against the intrusion into an individual's privacy. As the sensitivity of the personal information disclosed, and hence the intrusion on the right to confidentiality, increases, the burden on the state to justify a disclosure will increase under this balancing test. The court found that the disclosure of the highly personal information in the manner provided by Section 8, is not necessary to the State's pursuit of its interests. It was held that the State could easily fashion a statute that would strike a more appropriate and more constitutional balance between the right to privacy and protection of the Medicaid Program. Furthermore, the court felt that the psychiatrist whose office and records are searched has a Fourth Amendment expectation of privacy in the medical files even though the patients themselves may not have such reasonable expectation as to the records they do not possess. Thus, the Court concluded that the plaintiff's right to confidentiality was also violated by the administrative search provisions of the Medicaid Fraud Law. *Hawaii Psychiatric Soc. Dist. Branch v. Aoiyoshi*, 481 F. Supp. 1028 (D. Hawaii 1979).



This is not an easy time for her to stop smoking.

But it's not a good time for her baby to start.

The facts are in.

FACT: Women who smoke during pregnancy have smaller and lighter weight full term babies.

FACT: Their babies have more respiratory problems during the first critical years.

FACT: The incidence of stillborn infants and neonatal deaths is significantly greater.

FACT: The fetal oxygen supply is significantly reduced—the carbon monoxide in the blood significantly increased. There's more. Much more. Discuss the smoking hazard with your patients who are pregnant or planning a pregnancy. It may not be an easy time to quit smoking. But it's the right time.



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Office on Smoking and Health
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Brief Summary of Prescribing Information

Indications and Usage: Symptomatic relief of anxiety, tension, agitation, irritability an insomnia associated with anxiety neuroses and transient situational disturbances; anxiet associated with depressive symptoms and as a treatment of symptoms of anxiety if such symp toms are a significant feature of functional or organic disorders, particularly gastrointestinal c cardiovascular

Effectiveness in long-term use, i e., more than 4 months, has not been assessed by systen atic clinical studies Reassess periodically usefulness of the drug for the individual patient

Contraindications: Known sensitivity to benzodiazepines or acute narrow-angle glaucoma

Warnings: Not recommended in primary depressive disorders or psychoses As with all CNS acting drugs, warn patients on lorazepam not to operate machinery or motor vehicles, and c diminished tolerance for alcohol and other CNS depressants.

Physical and Psychological Dependence Withdrawal symptoms like those noted with barb turates and alcohol have occurred following abrupt discontinuance of benzodiazepine (including convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Addic tion-prone individuals, e g drug addicts and alcoholics, should be under careful surveillanc when on benzodiazepines because of their predisposition to habituation and dependence Withdrawal symptoms have also been reported following abrupt discontinuance of benzod azepines taken continuously at therapeutic levels for several months.

Precautions: In depression accompanying anxiety, consider possibility for suicide.

For elderly or debilitated patients, initial daily dosage should not exceed 2mg to avoid ove sedation

Terminate dosage gradually since abrupt withdrawal of any antianxiety agent may result i symptoms like those being treated anxiety, agitation, irritability, tension, insomnia and occa sional convulsions

Observe usual precautions with impaired renal or hepatic function.

Where gastrointestinal or cardiovascular disorders coexist with anxiety, note that lorazepar has not been shown of significant benefit in treating gastrointestinal or cardiovascular compc nent

Esophageal dilation occurred in rats treated with lorazepam for more than 1 year a 6mg kg day No effect dose was 1 25mg/kg/day (approximately 6 times the maximum huma therapeutic dose of 10mg day) Effect was reversible only when treatment was withdrawn withi 2 months of first observation Clinical significance is unknown; but use of lorazepam for pro longed periods and in geriatric patients requires caution and frequent monitoring for symptom of upper G I disease

Safety and effectiveness in children under 12 years have not been established.

ESSENTIAL LABORATORY TESTS Some patients have developed leukopenia; some have ha elevations of LDH As with other benzodiazepines, periodic blood counts and liver function tes are recommended during long-term therapy

CLINICALLY SIGNIFICANT DRUG INTERACTIONS Benzodiazepines produce CNS depressai effects when administered with such medications as barbiturates or alcohol.

CARCINOGENESIS AND MUTAGENESIS No evidence of carcinogenic potential emerged rats during an 18-month study No studies regarding mutagenesis have been performed.

PREGNANCY Reproductive studies were performed in mice, rats, and 2 strains of rabbit Occasional anomalies (reduction of tarsals, tibia, metatarsals, malrotated limbs, gastroschisi malformed skull and microphthalmia) were seen in drug-treated rabbits without relationship t dosage Although all these anomalies were not present in the concurrent control group, the have been reported to occur randomly in historical controls. At 40mg/kg and higher, there wa evidence of fetal resorption and increased fetal loss in rabbits which was not seen at lowe doses Clinical significance of these findings is not known. However, increased risk of congen tal malformations associated with use of minor tranquilizers (chlordiazepoxide, diazepam an meprobamate) during first trimester of pregnancy has been suggested in several studies Because use of these drugs is rarely a matter of urgency, use of lorazepam during this perio should almost always be avoided Possibility that a woman of child-bearing potential may b pregnant at institution of therapy should be considered Advise patients if they become pre nant to communicate with their physician about desirability of discontinuing the drug

In humans, blood levels from umbilical cord blood indicate placental transfer of lorazepar and its glucuronide

NURSING MOTHERS It is not known if oral lorazepam is excreted in human milk like othe benzodiazepines As a general rule, nursing should not be undertaken while on a drug sinc many drugs are excreted in milk

Adverse Reactions, if they occur, are usually observed at beginning of therapy and general disappear on continued medication or on decreasing dose In a sample of about 3,500 anxiou patients, most frequent adverse reaction is sedation (15 9%), followed by dizziness (6.9% weakness (4 2%) and unsteadiness (3 4%). Less frequent are disorientation, depression, nau sea change in appetite, headache, sleep disturbance, agitation, dermatological symptoms, ey function disturbance, various gastrointestinal symptoms and autonomic manifestations Inc dence of sedation and unsteadiness increased with age Small decreases in blood pressur have been noted but are not clinically significant, probably being related to relief of anxiety.

Overdosage: In management of overdosage with any drug, bear in mind that multiple agent may have been taken Manifestations of overdosage include somnolence, confusion and coma Induce vomiting and/or undertake gastric lavage followed by general supportive care, monito ing of vital signs and close observation. Hypotension, though unlikely, usually may be controlle with Levarterenol Bitartrate Injection U S P Usefulness of dialysis has not been determined

Ativan® (IV) for (lorazepam) Anxiety

Dosage: **Individualize for maximum beneficial effects. Increase dos gradually when needed, giving higher evening dose before increasin daytime doses. Anxiety, usually 2-3mg/day given b.i.d. or t.i.d.; dosag may vary from 1 to 10mg/day in divided doses. For elderly or debili tated, initially 1-2mg/day; insomnia due to anxiety or transient situa tional stress, 2-4mg h.s.**

How Supplied: **0.5, 1.0 and 2.0mg tablets.**

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Why one benzodiazepine and not another?

Are you concerned about long-acting metabolites? Many clinicians, as well as pharmacologists, are beginning to draw attention to this problem (see New England Journal of Medicine, April 5, 1979).

In contrast to some older benzodiazepines, Ativan (lorazepam) does not give rise to long-lasting active metabolites. As with all benzodiazepines, you should follow the usual precautions concerning co-administration with other CNS depressants and warn your patients against operating dangerous machinery and motor vehicles.

However, it is noteworthy that Ativan showed no clinical evidence of accumulation even when given in high doses over periods up to 6 months. The half-life of free lorazepam is about 12 hours; steady-state serum levels are attained in 2-3 days. Comparable data for diazepam: 20-50 hours and at least 7-10 days. (The pharmacokinetic profile of a drug can define such characteristics as absorption, distribution, metabolism and elimination but cannot, at present, be directly related to its therapeutic effectiveness.)

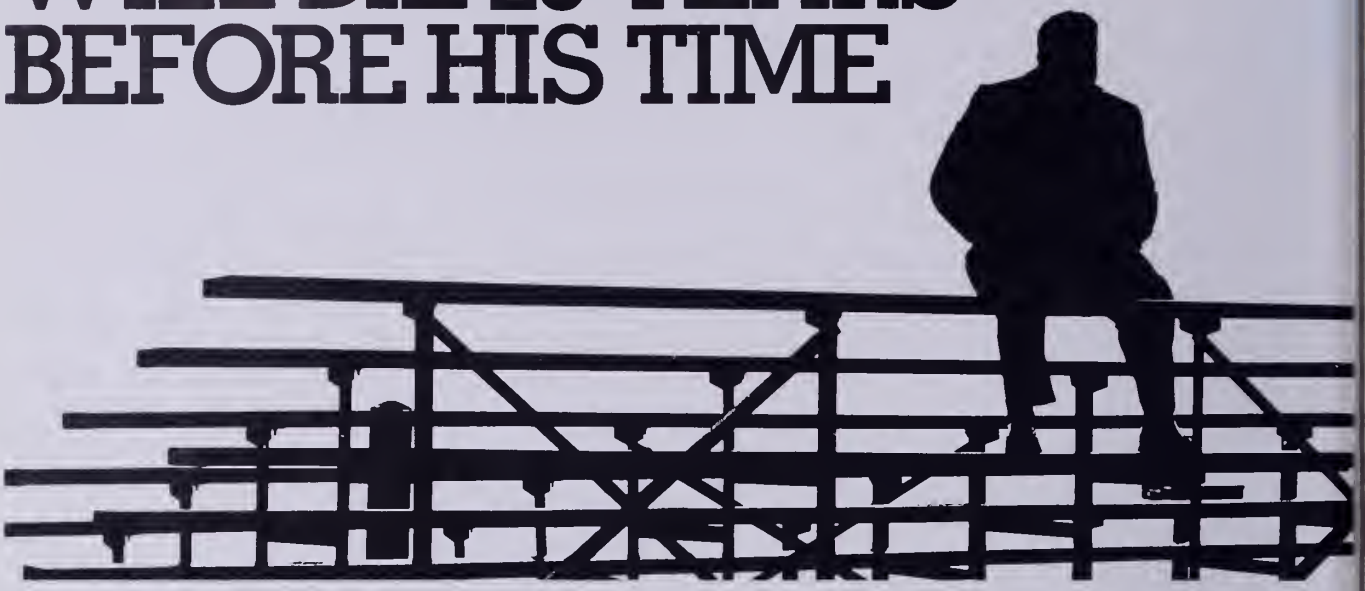
Ativan has a convenient b.i.d. or t.i.d. dosage schedule; it is compatible with a long list of other medications and, of course, it is a highly effective anxiolytic agent, as established in numerous nationwide, double-blind, controlled evaluations in thousands of patients.



See important information on preceding page.

Ativan® (lorazepam) for Anxiety

THIS FORMER ALL-STATE HALFBACK WILL DIE 20 YEARS BEFORE HIS TIME



Back in college he was always in great shape. But, like too many other Americans, the end of his college career signaled the end of his regular physical activity.

Years of business pressure, poor diet and a sedentary lifestyle have conspired to steal away his good health and cut years from his life expectancy. Now he's a prime candidate for heart disease—the number one cause of death and disability in the U.S.

Don't let the same thing happen to you. If you left your active lifestyle back in school, get moving again. Start a moderate program of regular lifetime sports like golf, tennis, biking, jogging, bowling or swimming. Start your new program with a check-up by your physician. It can help you feel better, look better and live better.

Just a little activity and recreation can make a big difference in your whole outlook on life. And the sooner you get moving, the longer you'll be able to move.

KEEP MOVING, AMERICA!

AAHPER

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Pioneers in Medicine For the Family

BOOTS PHARMACEUTICALS, INC.

Operating in the U.S. since 1977, Boots is a world-wide leader in pharmaceutical research and manufacture. Boots has directed its efforts toward providing products useful in the practice of family medicine.

Some of our better known products are Ru-Tuss® and Ru-Vert® . This advertisement highlights three other products particularly useful for the family.

F-E-P CREME® **TWIN-K®** **SU-TON®**





For the Majority of Steroid-Responsive Dermatoses* Seen in Family Practice

F-E-P CREME®

(Iodochlorhydroxyquin – Pramoxine HCl – Hydrocortisone)

The 4 in 1 Corticosteroid Cream

Anti-inflammatory, antifungal, antibacterial actions and, uniquely, a topical anesthetic for immediate relief of the itching or burning that frequently accompanies skin problems. One size (1/2 ounce), one strength for ease of prescription.

*This drug has been evaluated as possibly effective for these indications. See prescribing information on last page of this advertisement.

For Potassium Supplementation

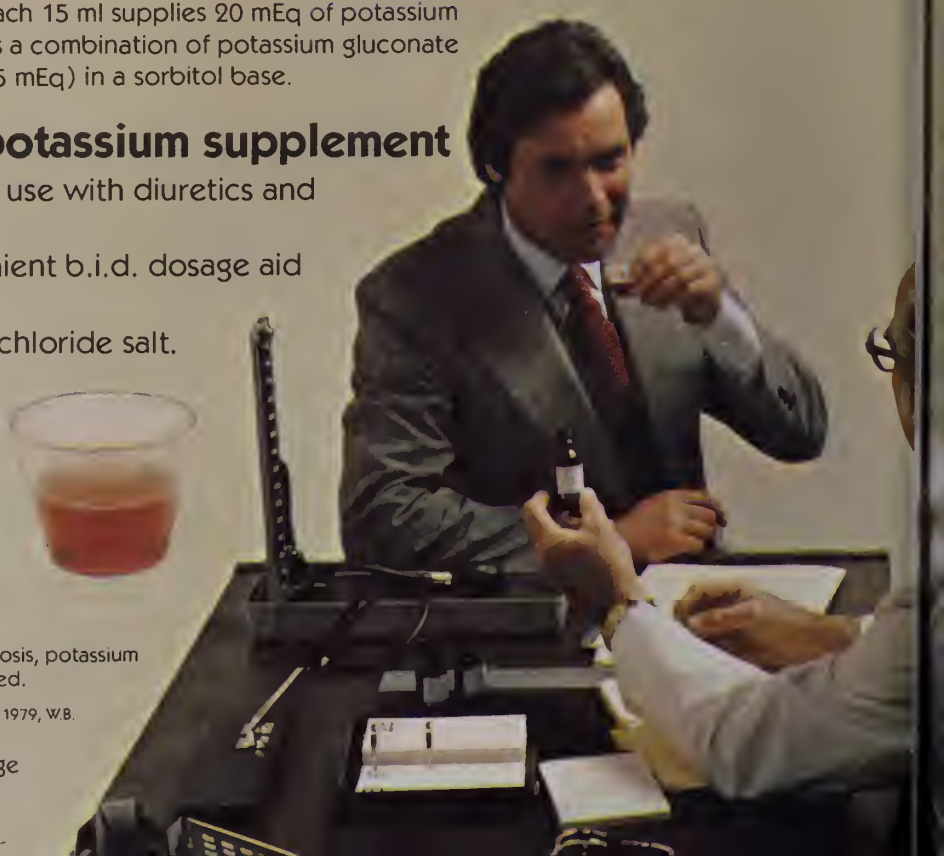
TWIN-K®

Each 15 ml supplies 20 mEq of potassium as a combination of potassium gluconate (15 mEq) and potassium citrate (5 mEq) in a sorbitol base.

The good tasting potassium supplement

- Designed for prophylactic use with diuretics and adrenocorticoids.
- Pleasant taste and convenient b.i.d. dosage aid patient compliance.
- Avoids the problems of a chloride salt.

"The organic salt can be given as a liquid without producing significant gastric symptoms and without an untoward effect on the mucosa of the small intestine."[1]



Note: In hypokalemic hypochloremic alkalosis, potassium chloride supplementation may be preferred.

1. Beeson-McDermott, Textbook of Medicine, 15th Ed 1979, W.B. Saunders Co., Philadelphia, p. 1959

See prescribing information on last page of this advertisement.

For the Geriatric Patient

SU-TON®

Liquid Tonic

A pleasant tasting prescription tonic containing iron, vitamins, minerals, an analeptic and 18% alcohol. Ideal for those who may benefit from vitamin deficiency prevention. Just one tablespoon before each meal.

Each 45 ml (3 tablespoonfuls) contains:

Pentylenetetrazol	30 mg
Niacin	50 mg
Vitamin B-1	10 mg
Vitamin B-2	5 mg
Vitamin B-6	1 mg
Vitamin B-12	3 mcg
Choline	100 mg
Inositol	50 mg
Manganese (as Manganese Sulfate)	1 mg
Magnesium (as Magnesium Sulfate)	2 mg
Zinc (as Zinc Sulfate)	1 mg
Iron (as Ferric Pyrophosphate, Soluble)	22 mg
Alcohol	18%

See prescribing information on last page of this advertisement.



Please send me patient starter samples of:

☐ **F-E-P CREME®**

☐ **TWIN-K®**

☐ **SU-TON®**

Name _____

Street Address _____

City _____ State _____ Zip _____

F-E-P CREME®

DESCRIPTION: F-E-P Creme is a topical water soluble anti-inflammatory, anesthetic, preparation intended for treatment of various inflammatory skin disorders. The drug contains the following active ingredients:

Iodochlorhydroxyquin	3.0%
Pramoxine Hydrochloride	0.5%
Hydrocortisone	1.0%

INDICATIONS AND USAGE:

Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, FDA has classified the indications as follows, "Possibly effective": Contact or atopic dermatitis; impetiginized eczema; nummular eczema; infantile eczema; endogenous chronic infectious dermatitis; stasis dermatitis, pyoderma, nuchal eczema and chronic eczematoid otitis externa; acne urticata; localized or disseminated neurodermatitis; lichen simplex chronicus; anogenital pruritus (vulvae, scroti, ani), folliculitis; bacterial dermatoses; mycotic dermatoses such as tinea (capitis, cruris, corporis, pedis); moniliasis; intertrigo. Final classification on the less-than-effective indications requires further investigation.

Pramoxine Hydrochloride promptly relieves pain and itch. This compound may be used safely on the skin of those patients sensitive to the "caine" type local anesthetics.

CONTRAINDICATIONS: Hypersensitivity to F-E-P Creme, or any of its ingredients or related compounds; lesions of the eye; tuberculosis of the skin; most viral skin lesions (including herpes simplex, vaccinia and varicella).

WARNINGS: This product is not for ophthalmic use. In the presence of systemic infections, appropriate antibiotics should be used.

USE IN PREGNANCY: Topical steroids have not been reported to have an adverse effect on pregnancy. However, fetal abnormalities have been produced in pregnant laboatory animals that have been exposed to large doses of topical corticosteroids. Drugs of this class should not be used extensively during pregnancy.

PRECAUTIONS: F-E-P Creme may be irritating to the skin in some patients. If irritation occurs discontinue therapy. Staining of clothes or hair may also occur with use of this preparation. Although systemic toxicity has not been reported with this drug, adrenal pituitary suppression is possible, especially when the drug is used extensively or kept under an occlusive dressing for a prolonged period. Iodochlorhydroxyquin can be absorbed through the skin and interfere with thyroid function tests. Therapy with this preparation should stop at least a month before performance of these tests.

The ferric chloride test for phenylketonuria (PKU) can be positive if F-E-P Creme is on the diaper or in the urine. Prolonged use of this drug may result in an overgrowth of nonsusceptible organisms requiring appropriate therapy.

ADVERSE REACTIONS: Skin rash or hypersensitivity may occur following topical application. The following local adverse reactions have been reported with topical corticosteroids, especially under occlusive dressings: burning, itching, irritation, dryness, folliculitis, hypertrichosis, acneiform eruptions, hypopigmentation, perioral dermatitis, allergic contact dermatitis, maceration of the skin, secondary infection, skin atrophy, striae, miliaria. Discontinue therapy if untoward reactions occur.

DOSAGE AND ADMINISTRATION: Apply a thin layer of the drug to affected parts 3-4 times daily.

Note:

1. **F-E-P Creme** is distributed with 3.0% iodochlorhydroxyquin for use when antibacterial/antifungal activity is desired.
2. **F-E-P Creme (Plain)** is the regular formulation, but without iodochlorhydroxyquin.

Both of these preparations contain pramoxine hydrochloride, which has topical anesthetic properties. Pramoxine is not chemically related to benzoic acid or amide type topical anesthetics. Patients can tolerate pramoxine although they may be sensitive to other "caine" type of topical or local anesthetics.

HOW SUPPLIED:

F-E-P Creme	F-E-P Creme Plain
½ ounce (15 gm) tubes	½ ounce (15 gm) tubes
NDC 0524-0026-51	NDC 0524-0025-51

CAUTION: Federal law prohibits dispensing without a prescription.

TWIN-K®

DESCRIPTION: Each 15 milliliter (tablespoonful) supplies 20 mEq of elemental potassium as a combination of potassium gluconate (15 mEq) and potassium citrate (5 mEq) in a sorbitol base with flavoring.

INDICATIONS AND USAGE: For use as oral potassium therapy in the prevention or treatment of hypokalemia which may occur secondary to diuretic or corticosteroid administration. It may be used in the treatment of cardiac arrhythmias due to digitalis intoxication.

CONTRAINDICATIONS: Severe renal impairment with oliguria or azotemia, untreated Addison's disease, adynamia episodica hereditaria, acute dehydration, heat cramps and hyperkalemia from any cause. This product should not be used in patients receiving aldosterone antagonists or triamterene

WARNINGS: TWIN-K (potassium gluconate and potassium citrate) is a palatable form of oral potassium replacement. It appears that little if any potassium gluconate-citrate penetrates as far as the jejunum or ileum where enteric coated potassium chloride lesions have been noted. Excessive, undiluted doses of TWIN-K may cause a saline laxative effect.

To minimize gastrointestinal irritation it is recommended that TWIN-K be taken with meals or diluted with water or fruit juice. A tablespoonful (15 ml) in 8 ounces of water is approximately isotonic. More than a single tablespoonful should not be taken without prior dilution.

PRECAUTIONS: Potassium is a major intracellular cation which plays a significant role in body physiology. The serum level of potassium is normally 3.8—5.0 mEq/liter. While the serum or plasma level is a poor indicator of total body stores, a plasma or serum level below 3.5 mEq/liter is considered to be indicative of hypokalemia.

The most common cause of hypokalemia is excessive loss of potassium in the urine. However, hypokalemia can also occur with vomiting, gastric drainage and diarrhea

Usually a potassium deficiency can be corrected by oral administration of potassium supplements. With normal kidney function it is difficult to produce potassium intoxication by oral administration. However, potassium supplements must be administered with caution since usually the exact amount of the deficiency is not accurately known. Checks on the patient's clinical status and periodic E.K.G. and/or serum potassium levels should be made. High serum potassium levels may cause death by cardiac depression, arrhythmias or arrest.

In patients with hypokalemia who also have alkalosis and a chloride deficiency (hypokalemic hypochloremic alkalosis), there will be a requirement for chloride ions. TWIN-K is not recommended for use in these patients.

ADVERSE REACTIONS: Symptoms of potassium intoxication include paresthesias of the extremities, flacid paralysis, listlessness, mental confusion, weakness and heaviness of the legs, fall in blood pressure, cardiac arrhythmias and heart block. Hyperkalemia may exhibit the following electrocardiographic abnormalities: disappearance of the P wave, widening and slurring of the QRS complex, changes of the ST segment and tall peaked T waves.

TWIN-K taken on an empty stomach in undiluted doses larger than 30 ml can produce gastric irritation with nausea, vomiting, diarrhea, and abdominal discomfort.

OVERDOSAGE: The administration of oral potassium supplements to persons with normal kidney function rarely causes serious hyperkalemia. However, if the renal excretory function is impaired potentially fatal hyperkalemia can result. It is important to note that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration with E.K.G. changes.

Treatment measures include:

1. Elimination of potassium containing drugs or foods.
2. Intravenous administration of 300 to 500 ml/hr of a 10% dextrose solution containing 10—20 units of crystalline insulin per 1000 milliliters.
3. Correction of acidosis.
4. Use of exchange resins or peritoneal dialysis.

In treating hyperkalemia it should be noted that patients stabilized on digitalis can develop digitalis toxicity when the serum potassium concentration is changed too rapidly.

DOSAGE AND ADMINISTRATION: The usual adult dosage is one tablespoonful (15 ml) in 6-8 fluid ounces of water or fruit juice, two to four times a day. This will supply 40 to 80 mE elemental potassium. The usual preventative dose of potassi 20 mEq per day while therapeutic doses range from 30 mI 100 mEq per day. Because of the potential for gastrointe irritation, undiluted large single doses (30 ml or more) or IV are to be avoided.

Deviations from this schedule may be indicated, since no ave total daily dose can be defined, but must be governed by observation for clinical effects.

HOW SUPPLIED: Pint bottles. NDC 0524-0021-16

CAUTION: Federal law prohibits dispensing without a pre tion.

SU-TON®

DESCRIPTION: Forty-five ml of SU-TON contains the fo ingredients:

Pentylenetetrazol	
Niacin	
Vitamin B-1	
Vitamin B-2	
Vitamin B-6	
Vitamin B-12	
Choline	
Inositol	
Manganese (as Manganese Sulfate)	
Magnesium (as Magnesium Sulfate)	
Zinc (as Zinc Sulfate)	
Iron (as Ferric Pyrophosphate, Soluble)	
Alcohol	

INDICATIONS AND USAGE: SU-TON contains pentylenete which may be helpful in the older patient as an analeptic when mental confusion and memory defects are present SI also contains vitamins, trace minerals, and iron, for those pa who may benefit by preventing the development of a defic

CONTRAINDICATIONS: Epilepsy, convulsive disorders or h history of sensitivity to any of the listed active ingredients.

WARNINGS: The safety of this preparation during pregnan lactation has not been established. Use of this drug requin the physician evaluate the potential benefits of the drug a any possible hazard to the mother and child.

PRECAUTIONS: Although there are no absolute contra tions to pentylenetetrazol, it should be used with caut epileptic patients or those known to have a low con threshold or a focal brain lesion. Caution should be exe when treating patients with high doses of SU-TON who hav disease. While pentylenetetrazol does not act directly o myocardium, the results from central vagal stimulation cause bradycardia.

ADVERSE REACTIONS: Pentylenetetrazol in high dose produce toxic symptoms typical of central nervous stimulants, which act on the higher motor centers and the cord. Convulsions resulting from this drug are spontaneo are not induced by external stimuli. They usually last for f minutes and are followed by profound depressio respiratory paralysis. Death has been reported from the in of 10 grams of pentylenetetrazol.

DRUG ABUSE: Drug dependence has not been reporte SU-TON.

OVERDOSAGE: Signs and symptoms of acute overdose r due principally from overstimulation of the central n system and from excessive vasodilatation with res autonomic nervous system imbalance. The symptoms may the following: vomiting, agitation, tremors, hyperreflexia, ing, confusion, hallucinations, headache, hyperp tachycardia. Treatment consists of appropriate supp measures. If signs and symptoms are not too severe a patient is conscious, gastric evacuation may be accompli induction of emesis or gastric lavage

Intensive care must be provided to maintain adequate tion and respiratory exchange.

DOSAGE AND ADMINISTRATION: One tablespoonful (1 times a day 20-30 minutes before meals. This drug is not fo children under 12 years of age.

HOW SUPPLIED:

Bottles of 473 ml (16 fl oz) NDC 0524-(

CAUTION: Federal law prohibits dispensing without a p tion.

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THE JOURNAL
OF THE FLORIDA MEDICAL ASSOCIATION INC
JULY 1980
VOL 67 • NO 7

Florida Medical Association House of Delegates Proceedings

One Hundred Sixth Annual Meeting Florida Medical Association, Inc. Hollywood, May 7 - 11, 1980

President's Address
Richard S. Hodes, M.D.

Richard S. Hodes, M.D., outgoing President of the Florida Medical Association addressed the House of Delegates during the opening session on Wednesday, May 7.

In reviewing the Association's activities over the past year, Dr. Hodes said serving as President has been a job he found challenging and enjoyable, and was sorry it was coming to an end. He advised that one of his major objectives during his tenure was to initiate an in-depth review of the FMA, its finances, Council and Committee structure, overall objectives, and management. Efforts were made to establish a better working liaison with the news media, which included visitations to the editorial boards of the state's major daily newspapers. An instant media response mechanism was also put into place, whereby the FMA responded immediately to any items affecting medicine.

He also called on Florida physicians to use restraint in the area of cost containment, including efforts to hold down fees in their practices as well as becoming more knowledgeable as to the cost of health care delivery to their patients in the hospital setting.

Dr. Hodes pointed to Workers' Compensation as an area of major achievement exemplified by FMA's successful petition for an increase in the physicians' medical and surgical fee schedule which resulted in an additional $16 million state-wide for physicians fees. He also commented that much progress had been made in improving the liaison with the Department of HRS, particularly in the State's Medicaid program, and pledged that efforts would continue to seek further improvements in Florida's Medicaid program, making it more responsive to the health care needs of the indigent with efficient and equitable administration.

Dr. Hodes said the various reports of the Board of Governors and FMA Councils included in the Delegates' handbook would reflect the great volume and broad scope of activities that have been carried out during the past year, as well as those issues that continue to threaten the private practice of medicine.

He expressed appreciation to all those physicians who served on FMA Committees and Councils during the past year, and thanked them for giving so freely of their time and talents in behalf of FMA.

He extended a special thanks to his Tampa legislative office staff who had been so helpful and efficient in coordinating his time for FMA responsibilities and activities with his legislative responsibilities.

Dr. Hodes ended by saying that he was grateful for having had the opportunity of serving FMA during the past year, and that it had been a particular pleasure to work with the high calibre of physicians who have served on the Board of Governors, and in the House of Delegates. He noted that each of them has represented their fellow physicians unselfishly and to the best of their ability.

Dr. Hodes extended his best wishes for the same rewarding experience to his successor, T. Byron Thames, M.D., and offered his fullest support in facing the crucial issues that continue to affect all physicians.



Dr. Hodes addressed the House of Delegates and reviewed the activities of the Association during the past year.

Fifty Years Ago

In *The Journal of the Florida Medical Association* for July 1930:

Spencer A. Folsom, M.D., of Orlando, contributed the lead scientific article entitled "Auricular Fibrillation"... A full-page advertisement sponsored by The Sugar Institute stated that "you get energy in a most refreshing form at your soda fountain" and implored Florida physicians to "refresh yourself with a flavored drink" . . . A maternity hospital in Pennsylvania advertised that it catered to "the better class unfortunate young women"... The Executive Committee of the Florida Heart Association, conducting its first meeting in Jacksonville, voted to affiliate with the American Heart Association . . . The wife of **Dr. T. W. Causey** of Lakeland saved the lives of their two sons who had fallen into a hole in Lake Morton . . . **Dr.** and **Mrs. Gordon H. Ira** of Jacksonville attended the annual conventions of the American Medical Association and the AMA Auxiliary in Detroit in June, 1930 . . . **Dr. Shaler Richardson,** Editor of *The Journal,* was married to the former Helen Hare in a ceremony that was "quietly performed" on June 20, 1930 . . .

And so it was in Florida medicine 50 years ago this month. — E.D.H.

First House of Delegates

The First House of Delegates convened at 4:30 p.m. on Wednesday, May 7, 1980, in the Regency Room North of the Diplomat Hotel, Hollywood, Florida, with Sanford A. Mullen, M.D., Speaker of the House presiding.

The House was led in singing the National Anthem by Mrs. Edie Epstein, accompanied by Mrs. Carolyn Davenport on the piano.

The invocation was given by Francis C. Coleman, M.D., of Hillsborough County.

Dr. Franklin H. Pfeiffenberger, Chairman of the Credentials Committee, reported that a quorum of 202 delegates were present representing 35 counties which constituted a quorum. Dr. Pfeiffenberger moved that the delegates be seated. The motion carried.

Delegates

ALACHUA — O. Frank Agee, M.D.; Thomas D. Bartley, M.D.; William B. Deal, M.D.; William T. Hawkins, M.D.; Douglas O. Jenkins, M.D.; Gerold L. Schiebler, M.D.; (Absent — Diane Zabak, Student Delegate)

BAY — Philip Cotton, M.D.; (Absent — James D. Nixon, M.D.)

BREVARD — Richard N. Baney, M.D.; Michael J. Foley, M.D.; Brian P. Gibbons, M.D.; Howard W. Pettengill, M.D.; Francis S. Pooser, M.D.; Robert J. Sarnowski, M.D.

BROWARD — Robert L. Andreae, M.D.; Leroy G. Appell, M.D.; Leonard C. Bass, M.D.; Donald A. Bolt, M.D.; Robert J. Brennan, M.D.; Phillip A. Caruso, M.D.; Milton P. Caster, M.D.; David A. d'Alessandro, M.D.; Burns A. Dobbins, M.D.; Arthur L. Eberly, M.D.; Kenneth H. Farrell, M.D.; Paul A. Flaten, M.D.; Stanley S. Goodman, M.D.; Theodore W. Hahn, M.D.; William C. Hartley, M.D.; James V. Redd, M.D.; Thomas F. Regan, M.D.; Joseph M. Sachs, M.D.; Peter A. Tomasello, M.D.; Anthony J. Vento, M.D.; Harry B. Weinberg, M.D.; (Absent — Bruce B. Burgess, M.D.; Ernest Costantino, M.D.; Wilbur F. Helmus, M.D.; James A. Jordon, M.D.; David C. Lane, M.D.; George P. Messenger, M.D.)

CAPITAL — Robert P. Johnson, M.D.; Nelson H. Kraeft, M.D.; Robert N. Webster, M.D.; (Absent — Jack W. MacDonald, M.D.)

CHARLOTTE — Thomas Civitella, M.D.; Charles H. Wingo, M.D.

CITRUS-HERNANDO — W. Randall Jenkins, M.D.; Clinton J. McGrew, M.D.

CLAY — Charles T. Dellinger, M.D.

COLLIER — Virgil A. Ponzoli Jr., M.D.; Joseph F. Sullivan, M.D.; (Absent — Donald Q. Vining, M.D.)

COLUMBIA — (Absent — Barney E. McRae, M.D.)

DADE — Armando F. A. Abadin, M.D.: Edward Annis, M.D.; Jerome



Sanford A. Mullen, M.D., Jacksonville, presents the traditional remarks of the Speaker at the opening session of the House of Delegates. Pictured (left to right): Secretary Robert E. Windom, M.D., Sarasota; Executive Vice President W. Harold Parham, D.H.A., Jacksonville; President Richard S. Hodes, M.D., Tampa; Dr. Mullen; Vice Speaker James B. Perry, M.D., Ft. Lauderdale; President-Elect T. Byron Thames, M.D., Orlando; Vice President William W. Thompson, M.D., Fort Walton Beach; Treasurer J. Russell Forlaw, M.D., Boynton Beach; and Past President O. William Davenport, M.D., Miami.

Benson, M.D.; Rufus K. Broadaway, M.D.; Luis Cabrera, M.D.; Manuel L. Carbonell, M.D.; Edmund Cava, M.D.; Jack Q. Cleveland, M.D.; Vincent P. Corso, M.D.; Joseph H. Davis, M.D.; Franklin J. Evans, M.D.; Miguel Figueroa, M.D.; N. Ralph Frankel, M.D.; George R. Gage, M.D.; Julian H. Groff, M.D.; Joseph Harris, M.D.; Walter Jones, III, M.D.; Robert B. Katims, M.D.; Norman M. Kenyon, M.D.; Melvin A. Klein, M.D.; Norman R. Korman, M.D.; Banning G. Lary, M.D.; Warren Lindau, M.D.; Carlos G. Llanes, M.D.; Simon E. Markovich, M.D.; Roberto Maury, M.D.; Burton T. Meadows, M.D.; Richard D. Miller, M.D.; Charles A. Monnin, M.D.; Miguel A. Mora, M.D.; Joseph T. Ostroski, M.D.; Jorge R. Pena, M.D.; Pedro A. Ramos, M.D.; Juan C. Richards, M.D.; Oscar Sandoval, M.D.; Janice K. Sherwood, M.D.; Everett Shocket, M.D.; S. William Simon, M.D.; David Sims, M.D.; Margaret C. S. Skinner, M.D.; Leonard S. Sommer, M.D.; Chauncey M. Stone, M.D.; David J. Talarico, M.D.; Charles F. Tate, M.D.; John C. Turner, M.D.; Thomas B. Turner, M.D.; Edgar W. Webb, M.D.; Harold H. Weiner, M.D.; Sheldon Zane, M.D.; Robert Marema — Student Delegate (Absent — Seymour Alterman, M.D.; Charles A. Dunn, M.D.; Walter M. Sackett, M.D.; Bruce W. Weissman, M.D.; Peter N. Weissman, M.D.)

DESOTO-HARDEE-GLADES — (Absent — Calvin W. Martin, M.D.)

DUVAL — James L. Borland, M.D.; James N. Burt, M.D.; Doris N. Carson, M.D.; Yank D. Coble, M.D.; Clyde Collins, M.D.; Patricia C. Cowdery, M.D.; Richard C. Dever, M.D.; Charles B. McIntosh, M.D.; Faris S. Monsour, M.D.; John A. Rush, M.D.; Guy T. Selander, M.D.; Robert H. Threlkel, M.D.; James W. Walker, M.D.; William D. Walklett, M.D. (Absent — Emmet F. Ferguson Jr., M.D.; Charles P. Hayes, M.D.; Walter G. Jarrell, M.D.; Jack L. Sapolsky, M.D.)

ESCAMBIA — Eric F. Geiger, M.D.; Charles H. Kahn, M.D.; Charles F. McConnell, M.D.; Robert K. Wilson, M.D.; Henry M. Yonge, M.D.; (Absent — Robert H. Cohan, M.D.)

FLAGLER — (Absent — John M. Canakaris, M.D.)

FRANKLIN-GULF — (Absent — Joseph P. Hendrix, M.D.)

HIGHLANDS — Robert T. Rengarts, M.D.; (Absent — Donald C. Hartwell, M.D.)

HILLSBOROUGH — Richard A. Bagby, M.D.; Francis C. Coleman, M.D.; Irving M. Essrig, M.D.; John C. Fletcher, M.D.; Thomas H. Greiwe, M.D.; Victor H. Knight, M.D.; Thomas E. McKell, M.D.; John K. Petrakis, M.D.; Michael J. Pickering, M.D.; Ralph E. Rydell, M.D.; William W. Trice, M.D.; James A. Winslow, M.D.; (Absent — Deborah Bradley — Student Delegate; Richard G. Connar, M.D.; Ronald L. Seeley, M.D.)

INDIAN RIVER — Ferdinand F. Becker, M.D.; (Absent — Donald L. Ames, M.D.)

LAKE — Frederick C. Andrews, M.D.; Robert Hux, M.D.

LEE — Cecil C. Beehler, M.D.; Larry P. Garrett, M.D.; John S. Hagen, M.D.; Francis L. Howington, M.D.; H. Quillian Jones Jr., M.D.

MADISON — (Absent)

MANATEE — Thomas R. Busard, M.D.; Arthur J. Cohen, M.D.; Julian J. Giraldo, M.D. (Absent — Salvatore J. Cantolino, M.D.)

MARION — C. Brooks Henderson, M.D.; Samuel L. Renfroe, M.D.

MARTIN — Fred S. Carter, M.D.; James A. Gray, M.D.

MONROE — (Absent — Robert D. Carraway, M.D.; Ronald H. Chase, M.D.)

NASSAU — (Absent — Jose L. Castillo, M.D.)

OKALOOSA — Eugene R. Valentine, M.D.; (Absent — David R. Arrowsmith, M.D.)

ORANGE — Edward Ackerman, M.D.; Francis M. Coy, M.D.; Clarence M. Gilbert, M.D.; Wm. Edward Hoffmeister, M.D.; David L. Mackey, M.D.; Joseph G. Matthews, M.D.; Franklin B. McKechnie, M.D.; Hector R. Mendez, M.D.; Louis C. Murray, M.D.; James F. Richards Jr., M.D.; Edward W. Stoner, M.D.; T. Byron Thames, M.D. (Absent — Sam F. Elder, M.D.; Robert B. Trumbo, M.D.)

OSCEOLA — George A. Gant, M.D.

PALM BEACH — Vernon B. Astler, M.D.; Richard C. Cavanagh, M.D.; John D. Corbit, M.D.; Lee A. Fischer, M.D.; J. Russell Forlaw, M.D.; James M. Johnson, M.D.; V. A. Marks, M.D.; Benjamin Moore, M.D.; Reginald J. Stambaugh, M.D.; Dick L. Van Eldik, M.D. (Absent — Jerry F. Cox, M.D.; Luis R. Guerrero, M.D.; Ben R. Thebaut Jr., M.D.)

PANHANDLE — Herbert E. Brooks, M.D.; James T. Cook Jr., M.D.

PASCO — (Absent — Robert D. May, M.D.; Morris L. Saperstein, M.D.)

PINELLAS — William W. Atkinson, M.D.; Charles K. Donegan, M.D.; John M. Hamilton, M.D.; Kay Knight Hanley, M.D.; David S. Hubbell, M.D.; Harold L. Ishler Jr., M.D.; Morris J. LeVine, M.D.; Jack A. MaCris, M.D.; Donald G. Nikolaus, M.D.; Rex Orr, M.D.; David T. Overbey, M.D.; Frederick O. Smith, M.D.; Walter H. Winchester, M.D.; (Absent — Thomas M. Daniel, M.D.; Michael Diamond, M.D.)

POLK — Howard M. DuBose, M.D.; Saul B. Gerber, M.D.; John W. Glotfelty, M.D.; Thomas E. McMicken, M.D.; James D. Morgan, M.D.; Paul A. Tanner Jr., M.D. (Absent — Salvadore J. Barranco, M.D.)

PUTNAM — Roy E. Campbell, M.D.

ST. LUCIE-OKEECHOBEE — Richard Stern, M.D. (Absent — William H. Meyer Jr., M.D.)

SANTA ROSA — (Absent — William N. Watson, M.D.)

SARASOTA — John N. Carlson, M.D.; Samuel E. Kaplan, M.D.; Kenneth C. Keihl, M.D.; Franklin Pfeiffenberger, M.D.; Karl R. Rolls, M.D. (Absent — Richard C. Rehmeyer, M.D.)

SEMINOLE — Luis M. Perez, M.D.; Frederick J. Weigand, M.D.

SUWANEE-HAMILTON-LAFAYETTE — (Absent)

TAYLOR — (Absent — John A. Dyal, M.D.)

VOLUSIA — Charles R. DeArmas, M.D.; William R. Jones, M.D.; Beatrice T. Silverman, M.D.; Alvin E. Smith, M.D.; Charles A. Stump, M.D. (Absent — Frank J. Lill, M.D.)

WALTON — (Absent — Howard F. Currie, M.D.)

WASHINGTON — (Absent — John T. Grace, M.D.)

SPEAKER OF THE HOUSE — Sanford A. Mullen, M.D.

VICE SPEAKER OF THE HOUSE — James B. Perry, M.D.

Clarifications to the Rules and Order of Business

The Speaker stated that the Order of Business is as listed in the Handbook, however, he made the following clarifications:

First, he clarified the nominations for the Committee on Membership and Discipline. A list of nominees is provided by the Board of Governors; however, at the time of the actual election, the House has the privilege of presenting additional nominees from the floor and they will be voted on at that time.

Second, the Speaker called attention to the item of Resolutions in the Handbook. He explained that a sponsor must appear before a Reference Committee or the Resolution will not necessarily have to be heard. However, since the Resolution is the property of the House once it has been officially referred to a Reference Committee, the Reference Committee does have the option to discuss the Resolution if a sponsor is not present and they deem it appropriate.

There were no objections, and a motion to adopt the Rules and Order of Business which appear in the Handbook on pages 3 and 18-20 carried.

Information for Delegates

The Rules and Order of Business for the House of Delegates is included in this Handbook.

Delegates and alternates whose names appear in this Handbook have been certified by their county medical societies. Our By-Laws do not permit an alternate to serve for a delegate who has once been seated. The By-Laws require that delegates fill out attendance cards at each meeting of the House of Delegates in order to be credited in attendance, and further, the chairman of the Credentials Committee is required to report to the House the number of delegates who have registered their attendance cards, thus eliminating the necessity of a roll call to seat delegates.

Reports and resolutions that were received before going to press are included in this Handbook. Delegates are urged to study them carefully before they are introduced in the House. Wherever possible, it is requested that resolutions and supplemental reports be forwarded to the Association's executive office by April 30 for duplication and distribution to the delegates.

Your attention is called to the format of the annual meeting, where the Reference Committee meetings will be held in the morning following the First Meeting of the House. All reports and resolutions will be referred to Reference Committees by the Speaker at the First Meeting of the House of Delegates. All members who are interested in any committee report or resolution should attend the Reference Committee meetings where a full discussion will take place. Council and committee chairmen are respectfully requested to be present and discuss their respective reports. All members of Reference Committees are urged to study carefully the reports and resolutions referred to them. The chief purpose of the Reference Committees is to allow an opportunity for as many members of the Florida Medical Association as possible to appear and be heard and thus have a voice in the business of the Association. In addition, discussions before the Reference Committees have the added advantage of avoiding long discussions at the meetings of the House of Delegates. Members may request the Reference Committee chairman to defer items in which they are interested in order that they may be present to discuss the subject.

All resolutions **must have a sponsor present** before the Reference Committee. Resolutions must be filed by 12:00 noon on the day of the First Meeting of the House of Delegates, typewritten and in proper form. The resolutions so presented will be available for distribution by the time the First House convenes. Only the "Resolved" portion of the resolutions will be adopted as policy.

All Reference Committee reports will be duplicated and available to the delegates at the Registration Desk on Saturday morning. We trust these provisions will result in an efficient and informed House of Delegates.

All reports and resolutions included in this Handbook, those which will be in the Delegates' Packets, and the reports of the Reference Committees have been printed on colored paper for easy reference. This color code is as follows:

Reference Committee No. I — Green
Reference Committee No. II — Buff
Reference Committee No. III — Blue
Reference Committee No. IV — Pink
Reference Committee No. V — Goldenrod

According to our By-Laws, nominations and seconding speeches shall be limited to a maximum of two minutes each. If additional information needs to be presented, it should be duplicated and distributed to members of the House.

Your Speaker and Vice Speaker are available at any time to help in any way in the preparation of resolutions or in any capacity in which they might help any member of the Florida Medical Association.

Sanford A. Mullen, M.D., Speaker
House of Delegates
James B. Perry, M.D., Vice Speaker
House of Delegates



Sanford A. Mullen, M.D., Speaker of the House, addresses Delegates.

With the increasing volume and complexity of the business before the House, your Speaker and Vice Speaker deemed it advisable to designate a Parliamentarian. With the approval of the House, Dr. Louis C. Murray was asked to serve as Parliamentarian for the 1980 House of Delegates.

The Speaker introduced the officers of the Association: James B. Perry, M.D., Vice Speaker; Richard S. Hodes, M.D., President; O. William Davenport, M.D., Immediate Past President; T. Byron Thames, M.D., President-Elect; J. Russell Forlaw, M.D., Treasurer; Robert E. Windom, M.D., Secretary; and W.

Harold Parham, D.H.A., Executive Vice President.

A motion carried to adopt the minutes of the 1979 House of Delegates as published in the July 1979 issue of *The Journal of the Florida Medical Association.*

Dr. Mullen, Speaker, advised that during the past year a number of FMA members had departed this life. In memory of these physicians, roses had been placed in the vases at each end of the Speaker's podium. Dr. Mullen asked that the House observe a moment of silent prayer in respect and memory of these members.

The Speaker then instructed the House.

Remarks — Speaker of the House

Ladies and Gentlemen of the House of Delegates of the Florida Medical Association, it is a very high honor for me to address you as your speaker. This meeting is the second occasion on which this responsibility has been given to me. I will pledge to you that I will make every effort to see that the deliberations and actions of this House proceed in the most efficient manner possible. My objective is to be sure that the rule of the majority prevails and that every minority opinion will be given appropriate courtesy and consideration so that each Delegate will feel that he or she is fully a part of this great body.

I would remind the Delegates that we operate under the charter and bylaws of the Florida Medical Association with parliamentary procedure determined by Sturgis' Standard Code of Parliamentary Procedure unless otherwise provided in the charter or bylaws. At any time the parliamentary procedure may be waived or modified by a two-thirds vote of the members present.

We have approximately 250 voting Delegates who represent all of the organized county medical societies. In addition there are approximately 100 individuals who have the privilege of the floor. These individuals do not have the right to vote but are allowed to make motions provided that they are seconded by voting members of the House. The presiding officer may grant the privilege of the floor to others whenever he deems it necessary.

I would urge each of you to obtain a copy of Sturgis in order to become more familiar with parliamentary procedure. It is highly desirable to have this text available at all times during meetings of this and other organizations which are governed by its rulings. The duties of Delegates are well defined in Sturgis and I would like to quote a paragraph which clearly delineates the responsibilities.

> "The first duty of a Delegate is to vote for what he believes is best for the organization as a whole; his second duty is to vote for what is best for the particular group that he represents. He is first a legislator for the whole organization and second a spokesman for his particular group. The Delegate should understand thoroughly how the members of his group feel about the proposals to be voted on but should be trusted to follow his own best judgment in evaluating and voting on measures as they are finally presented for decision."

During the next few days each of you will be called on to make important decisions relative to the future of the Florida Medical Association in particular and the practice of medicine in Florida in general. This is a great responsibility and one that should not be entered into lightly.

The deliberations of the House of Delegates function by a system of reference committees. There are five reference committees of the House this year. Each of these committees is composed of five voting members of this House with one or two AMA Delegates and alternate Delegates as advisory members. To each of these committees will be referred reports and resolutions which encompass the full scope of all FMA activity during the past year as well as proposals for future activities of the FMA. No item of any importance in the FMA organization is spared the surveillance of the reference committees.

The reference committees will hold hearings at which all members of the FMA are welcome. It is important for you as delegates to participate in the hearings of as many of these reference committees as possible. Following the hearings the reference committees will go into executive session and prepare their reports. Their efforts will be assisted by a recording secretary and a senior FMA staff person who will provide technical information to the committees on the subjects for which they are responsible.

The reports of the committees will be ready for distribution to all Delegates by Saturday morning, May 10, at 8:00 a.m. A single advance copy will be available to each county delegation by Friday afternoon. It is these reports which will be considered at the second and third House of Delegates meetings which are scheduled for this Saturday and Sunday.

It is hoped that most of the discussion and debate relative to the issues referred to the reference committees will take place during the hearings of the reference committees. At those hearings each matter can be considered in minute detail. While we would certainly not wish to limit debate on the floor of the House of Delegates during the second and third sessions, we would urge you to make your discussions during the second and third House as concise and pertinent as possible. In this way, we will not have unnecessarily prolonged sessions and yet each of you will have the opportunity to discuss matters of particular interest to you when the problem has not been solved to your satisfaction by the reference committee system.

At this time I would like to say that each of us owes a debt of gratitude to the individuals who will be serving as members of the reference committees. Each of these Delegates, by serving on reference committees, will be giving up significant amounts of time from other activities in which he may desire to participate. Your vice speaker and I have made every effort to see that the members of the reference committees represent all parts of the state and are broadly represented among the various medical specialties. We would also suggest to you that your county medical societies would be well advised to make recommendations of qualified Delegates who might be able and willing to serve on reference committees in the future. Reference committee work is one of the most gratifying FMA experiences any of us can have.

The meeting ahead promises to be most productive. I would urge all of you to involve yourself completely in the various activities which will be available during the next few days. It is a unique and important experience for us to come together at the annual meeting of the FMA and share views and have the intellectual stimulation of interaction with our colleagues from all over our great state.

Your vice speaker and I stand ready at any time to be of service to help you with any problem that might arise. Do not hesitate to let us know if you need our assistance. I am sure, that by working together in the next few days, all of us can do much to make certain that we are charting a proper course for the FMA through the dangerous seas which we face in the days ahead, both as citizens of this great country and as physicians who have the primary responsibility for seeing that all Floridians have access to the best possible medical care.

The remarks of the Speaker of the House of Delegates were referred to Reference Committee No. III for consideration.

Dr. Richard S. Hodes, President, assumed the chair to present the A.H. Robins Company Award for "Outstanding Community Service by a Physician". Dr. Hodes requested the Delegates of the Manatee County Medical Society to escort Willett E. Wentzel, M.D., to the podium to receive the award.



Willett E. Wentzel, M.D., Bradenton, proudly displays his A. H. Robins Company Award for Outstanding Community Service by a Physician, as FMA President Richard S. Hodes, M.D., looks on.

A. H. Robins Company Award For Outstanding Community Service By A Physician

Whereas, Willett E. Wentzel, M.D., of Bradenton, Florida, has practiced and been a leader in the medical community of Manatee County since 1937; and

Whereas, This native of Oshkosh, Wisconsin, with the exception of two years as a flight surgeon during World War II, has applied his ample talents not only in the practice of medicine, but also in planning for the future medical needs of the community; and

Whereas, He helped organize a campaign to erect a new hospital and has served on the Board since it opened in 1953, twice as its Chairman; and

Whereas, He has been honored as Manatee County's Distinguished Citizen in 1975, has served as President of the Bradenton Kiwanis Club, been a member of the Manatee Players, a Member of the Board of the DeSoto Celebration, the South Florida Museum and the Bishop Planetarium; and

Whereas, With the help of his lovely wife, the former Margaret Turner of Bradenton, has reared two children: Bill Wentzel who resides in Naples and a daughter, Mrs. Gillion Ward, the wife of a Coral Gables physician; therefore be it

RESOLVED, That the Board of Governors, the members and staff of the Florida Medical Association convey to Willett E. Wentzel, M.D., sincere best wishes and appreciation as the recipient of the A. H. Robins Company Award for Outstanding Community Service by a Physician.

Dr. Wentzel expressed his appreciation to the Association and his fellow physicians and to his wife and family who have stood by him during his endeavors.

Dr. Mullen asked Dr. James Sammons, Executive Vice President of the AMA, to come to the podium. Dr. Sammons, asked the Delegates from Seminole County to escort Dr. Luis M. Perez to the podium. Dr. Sammons presented Dr. Perez with a Certificate of Appreciation for his outstanding leadership and efforts on behalf of all foreign medical graduates in the country, working diligently on the AMA Special Committee to study the problems of the foreign medical graduates and their assimilation into the medical practice of the United States.

Certificate of Appreciation American Medical Association

"The American Medical Association presents to Luis M. Perez, M.D., this Certificate of Appreciation in recognition of his contributions to American Medicine and Foreign Medical Graduates as a member of the AMA's Ad Hoc Committee for FMG Affairs, 1978-1980. In witness whereof, the Seal of the Association and the signatures are hereunto affixed."

Dr. Perez thanked Dr. Sammons and the AMA for this honor and assured all that they could count on what ability he has and every ounce of effort he has to preserve medicine as it is in the United States in the hands of the private practitioner and live it through organized medicine within the states, under the leadership of the AMA.

Dr. Sammons then addressed the House of Delegates summarizing some of the governmental controls and regulations now being placed on physicians and expressed his concern of such regulation. He stressed the fact that the medical profession is the only part of the American economy that has voluntarily reduced its escalation through various programs at a time when total escalation in economy is 18%, and in the past two years has reduced hospital expenditures by $3 billion dollars. Dr. Sammons expressed his concern that 90-91% of the physicians of Florida belong to the Florida Medical Association, yet only 47-48% of that group belong to the AMA, and half of the profession in the country do not belong to their county or state association or the AMA. Dr. Sammons emphasized that the image of the physician starts at the office; and when the strength of medicine is coming from unity, says to the people who make the laws and write the regulations, "No, you will not interfere in the practice of medicine". Dr. Sammons stressed the only way to change things was to participate and encouraged all Florida physicians to do this.

Dr. James Perry, Vice Speaker, introduced Mrs. B. David Epstein, President of the Florida Medical Association Auxiliary. Mrs. Epstein summarized some of the activities of the Auxiliary during the past year. Dr. Perry then introduced Mrs. Fred W. Swing, President-Elect of the Florida Medical Association Auxiliary and Mrs. John

F. Vaughan, President-Elect of the American Medical Association Auxiliary. Mrs. Vaughan expressed her appreciation for the opportunity to speak to the House of Delegates and asked physicians to encourage their wives to participate in the Auxiliary. Dr. Perry introduced Dr. Edward R. Annis, Past President of the AMA; Dr. James W. Walker, President of PIMCO and Past Officer of the FMA; Mr. William Flaherty, President of Blue Shield of Florida, Jacksonville; Mrs. Linus W. Hewit, AMA Auxiliary Board Member; Mrs. Raymond Raw, President of the Sourthern Medical Association Auxiliary; and Mrs. Connie Moore, Past President of the FMA Auxiliary.

Dr. Mullen introduced the President, Dr. Richard S. Hodes. Dr. Hodes addressed the House (See page 624 for the complete text of the President's address).

The President's Address was referred to Reference Committee No. III.

Dr. Mullen resumed the chair and announced the members of the Reference Committees, the assignment of AMA Delegates to the Reference Committees and the times that each Reference Committee would meet.

Reference Committee No. I — Health and Education
H. Quillian Jones, M.D., Chairman
Barney E. McRae, M.D.
Richard B. Moore, M.D.
Jerome Benson, M.D.
Irving M. Essrig, M.D.
Richard G. Connar, M.D. and William J. Dean, M.D. — AMA Delegate Advisors

Reference Committee No. II — Public Policy
Roy E. Campbell, M.D., Chairman
Thomas R. Busard, M.D.
William C. Hartley, M.D.
Warren Lindau, M.D.
Robert P. Johnson, M.D.
Samuel M. Day, M.D. and Vincent P. Corso, M.D. — AMA Delegate Advisors

Reference Committee No. III — Finance and Administration
Manuel L. Carbonell, M.D., Chairman
Thomas D. Bartley, M.D.
John N. Carlson, M.D.
Brian P. Gibbons, M.D.
Walter H. Winchester, M.D.
Charles K. Donegan, M.D. and Vernon B. Astler, M.D. — AMA Delegate Advisors

Reference Committee No. IV — Legislation and Miscellaneous
Guy T. Selander, M.D., Chairman
Victor H. Knight Jr., M.D.
Reginald J. Stambaugh, M.D
Pedro A. Ramos, M.D.
Virgil A. Ponzole, M.D.
Joseph C. Von Thron, M.D. and Francis C. Coleman, M.D. — AMA Delegate Advisors



James Sammons, M.D. (left), Executive Vice President of the American Medical Association, presents a Certificate of Appreciation to Luis Perez, M.D., of Sanford. Dr. Perez was cited for his work as a member of the AMA's Ad Hoc Committee for Foreign Medical Graduate Affairs.

Reference Committee No. V — Medical Economics
Clarence M. Gilbert, M.D., Chairman
Charles J. Kahn, M.D.
David S. Hubbell, M.D.
Robert B. Katims, M.D.
Arthur L. Eberly, M.D.
Rufus K. Broadaway, M.D. and Eugene G. Peek Jr., M.D. — AMA Delegate Advisors

Dr. Mullen announced that the assignment of reports and resolutions to Reference Committees were as indicated in the Handbook.

The Vice Speaker announced the assignment of Supplemental Reports and Resolutions which were received too late for inclusion in the Handbook, and which had been inserted into the Delegate's packets, were as indicated on the reports.

Dr. Charles F. Tate, Dade County, requested permission of the House to present an additional resolution, FMA State Health Plan. The House voiced no objection, the resolution was assigned Resolution No. 80-14, added to the agenda, and referred to Reference Committee No. V for consideration.

The Speaker announced that there would be a Health Run on Saturday morning at 7:30 a.m.

The Speaker brought to the attention of the House the dates and times of the Blue Shield Informational Meeting, the Special Program on Impaired Physicians, the General Session, the FLAMPAC-Auxiliary Luncheon, and the President's Reception, "Mardi Gras Spectacular".

The House recessed at 6:00 p.m. to reconvene on Saturday, May 10, at 3:00 p.m.

General Session

The General Session of the 106th Annual Meeting of the Florida Medical Association was called to order at 11:00 a.m. on Friday, May 9, 1980, in the Regency Room North of the Diplomat Hotel, Hollywood, Florida, by the President, Richard S. Hodes, M.D.

Dr. Hodes introduced persons seated at the head table, and then asked Dr. Eugene G. Peek Jr., President of the Florida Medical Foundation, and Mrs. B. David Epstein, Immediate Past President of the FMA Auxiliary, to come to the podium to make presentations of grants from the AMA-ERF to Medical School Deans. Dr. Peek made the following presentations: $9,776.00 to Dr. William B. Deal, Dean, University of Florida College of Medicine, Gainesville; $6,784.00 to Mr. Michael Balsam, Associate Dean for Medical Development, University of Miami School of Medicine; $10,341.00 to Dr. Frank Cozzetto, Associate Dean for Continuing Medical Education, University of South Florida College of Medicine; and $210.00 to Dr. William Deal representing Florida State University.

On behalf of the Auxiliary of the Florida Medical Association, Mrs. B. David Epstein presented Dr. Peek, President of the Florida Medical Foundation, with a check in the amount of $6,110.96 designated for the Florida Medical Association's Impaired Physician Program.

Dr. Hodes announced the winners of the 1980 Scientific/Educational Exhibit Awards.

1980 Scientific/Educational Exhibit Awards

Honorable Mention

"The Scope of Plastiç Surgery and Rejuvenation of the Aging Face"
Florida Society of Plastic and Reconstructive Surgery — S. Anthony Wolfe, M.D., Miami

"Congenital Hypertrophic Pyloric Stenosis"
Departments of Pediatrics and Surgery, University of Florida College of Medicine — Bradley M. Rogers, M.D., James Talbert, M.D., Frederick Rychman, M.D. and Farhat Moazam, M.D., Gainesville.

Third Place

"Glaucoma Today"
University of South Florida College of Medicine, Department of Ophthalmology, and Florida Affiliate, National Society to Prevent Blindness — William E. Layden, M.D., Tampa.

Second Place

"Operative Mitral Valve Disease"
North Ridge General Hospital Cardiovascular and Pulmonary Educational and Research Foundation, Inc. — James R. Jude, M.D., Robert E. Cline, M.D. and Ali Ghahramani, M.D., Fort Lauderdale.

First Place

"Trans Patellar Tendon Arthroscopy of the Knee"
Richard G. Onkey, M.D., Naples, Florida

The President then called Dr. Gerold Schiebler, Editor of *The Journal,* to the platform to assist in pre-



Checks totaling more than $27,000 in AMA-ERF gifts were presented to the medical schools by Mrs. B. David Epstein (second from right), President of the FMA Auxiliary, and Eugene G. Peek Jr., M.D. (right), President of the Florida Medical Foundation. Checks were received by (left to right): Mr. Michael Balsam, Associate Dean for Medical Development, University of Miami School of Medicine; Frank Cozzetto, M.D., Associate Dean for Continuing Medical Education, University of South Florida College of Medicine; and William B. Deal, M.D., Dean, University of Florida College of Medicine.





Awards in the Third Annual Journal of the Florida Medical Association Contest for County Medical Society Bulletins were presented during the General Session on Friday, May 9. In upper left photo, Manuel Carbonell, M.D., President of the Dade County Medical Association, receives the First Place Award for General Excellence from FMA President Richard S. Hodes, M.D. Francis C. Coleman, M.D. (upper right), President of the Hillsborough County Medical Association, received on behalf of the Bulletin of HCMA citations for best regular feature and honorable mention in general excellence. In middle right photo, FMA Delegate H. Quillian Jones Jr., M.D., accepts for the Lee County Medical Society Bulletin the award for best editorial. At bottom right, Editor Henry L. Harrell Jr., M.D., of the Marion County Medical Society Bulletin, receives an award for best new county medical society bulletin. In lower left photo, William C. Hartley, M.D., President of the Broward County Medical Association, displays the "most improved bulletin award" presented to the BCMA Record; William E. Price, M.D., President of the Capital Medical Society, shows the plaque awarded to the Capital Medical Society Newsletter for continued excellence in Editorial Writing; and Editor F. Norman Vickers, M.D., of the Escambia County Medical Society Bulletin, displays a special recognition plaque.







senting the awards for the Third Annual JFMA Awards Contest for County Medical Society Bulletins.

Winners of Third Annual JFMA Awards Contest For County Medical Society Bulletins

General Excellence
The winner of this category is *Miami Medicine*, Edward W. St. Mary, M.D., Editor.

Honorable mention for General Excellence, *The Bulletin of the Hillsborough County Medical Association*, Louis E. Cimino, M.D., Editor.

Most Improved Bulletin
The winner of this category is *The Broward County Medical Association Record*, Lees M. Schadel, M.D., Editor.

Best Editorial
The winner in this category is *Lee County Medical Society Bulletin*, "Comfort Always", Thomas M. Wiley Jr., M.D., Editor.

Special Citation for Continued Excellence in Editorial Writing
The winner is *The Capital Medical Society Newsletter*, James K. Conn, M.D., Editor.

Best Regular Feature
The winner in this category is *The Bulletin of the Hillsborough County Medical Association*, "Read and Reflect", Louis E. Cimino, M.D., Editor.

Special Recognition
There were two winners in this category: *Escambia County Medical Society Bulletin* for the column "Chit and Chat", F. Norman Vickers, M.D., Editor; and *Marion County Medical Society Bulletin* for the best new county medical society bulletin, Henry L. Harrell Jr., M.D., Editor.

Dr. Hodes introduced Mr. Sander Vanocur who presented the annual Baldwin Lecture.

Mr. Vanocur, Vice President for ABC-TV and a journalistic veteran of six presidential campaigns launched a critique of the increasingly important role television is playing in the political process.

The political system of yesteryear is gone, according to Mr. Vanocur, and has been replaced by the media, particularly television. The process was a slow one, beginning with such entities as the Dinah Shore Show and the Huntley Brinkley Report and culminating with the public acceptance of "the way it is" as told by Walter Cronkite. The power of television in the political arena was fully recognized in the 1960 election when Richard Nixon's defeat by John Kennedy was attributed to a great degree to the performance (and public acceptance) of both candidates in the famous televised debates.

1968 was the year television political coverage was elevated from a position as spectator and reporter to participant, Mr. Vanocur recalled. "The Democratic Convention in Chicago . . . was a crossover moment for



Baldwin Lecturer Sander Vanocur, Vice President of ABC News, is greeted at podium by President Richard S. Hodes, M.D., Tampa (right).

television as the new political sovereignty. The students in Grant Park shouted, 'the whole world is watching!' I don't know if the whole world was watching, but America was, and what it saw of us, of our performance, it didn't like. It may have been right in this, but for the wrong reasons. We, I think, had crossed over — we were probably pushed over — over that line that divides the observers from participants in the political process. We didn't wish to cross that line or to be pushed across it, but we crossed it nevertheless, and having crossed over, I don't think that our role in American politics has ever been the same since," he noted.

By 1972, television had become THE means by which most Americans received their information, and political campaigners maximized on that condition, and television reporters realized the capacity they had to shape public opinion. Mr. Vanocur cited as an example the visual image offered to Americans of Presidential candidate Edmund Muskie standing on a flatbed truck in the snow before the offices of the Manchester (New Hampshire) Union Leader defending an attack on his wife. The key to the scene was the fact that Muskie had moisture on his cheeks which was identified by reporters as tears. The moisture may have been melting snow, Mr. Vanocur speculated, but only those who were there will ever know.

The situation has been worsening in subsequent years, Mr. Vanocur stated, and "... the television box and the way it is used — the candidates, the anchormen, the polls that are displayed on television and the political commercials — all these elements have become almost totally our political system — there seems really very

little else. You may say there is still a political system left — it is exemplified daily in the halls of Congress or the State Legislatures — perhaps there is. But I wonder if it is a system that has avoided the dominance of television, or if this system . . . is as good as it once was."

Mr. Vanocur contended that it is time to return to some of the basics of the political system, perhaps even "the smoke-filled room." The change is necessary, but will not come about through the efforts of the media, he said, adding, "If something is not done soon I think the political process will continue to deteriorate to the point that there is going to be a revulsion against it — against what it has been transformed into by television. And we who are in television will be charged with the ultimate debasement since we have become the political process itself. We may plead innocence, but that is not going to work, for to many, innocence is the highest form of immorality."

Dr. Hodes adjourned the meeting at 12:00 p.m.



Seventeen of FMA's living Past Presidents got together during the Annual Meeting for their annual breakfast and shop talk. Seated (left to right): H. Phillip Hampton, M.D., Tampa (1965); Samuel M. Day, M.D., Jacksonville (1964); Walter C. Jones, M.D., Miami (1941); Jere W. Annis, M.D., Lakeland (1958); Leo M. Wachtel, M.D., Jacksonville (1960); and George S. Palmer, M.D., Tallahassee (1966). Standing: Henry J. Babers Jr., M.D., Gainesville (1969); Louis C. Murray, M.D., Orlando (1977); O. William Davenport, M.D., Miami (1978); Thad Moseley, M.D., Jacksonville (1974); Jack A. MaCris, M.D., St. Petersburg (1976); Vernon B. Astler, M.D., Boynton Beach (1975); William J. Dean, M.D., St. Petersburg (1972); Jack Q. Cleveland, M.D., Coral Gables (1968); W. Dean Steward, M.D., Marianna (1967); Joseph C. Von Thron, M.D., Cocoa Beach (1973); and James T. Cook, M.D., Marianna (1970).

Second House of Delegates

The Second Meeting of the House of Delegates convened at 3:00 p.m., Saturday, May 10, 1980, in the Regency Room North of the Diplomat Hotel, Hollywood, Florida, with Dr. Sanford A. Mullen, Speaker of the House, presiding.

Dr. Franklin H. Pfeiffenberger, Chairman of the Credentials Committee, reported that 237 delegates were present with 35 component societies represented, constituting a quorum, and moved the delegates be seated. The motion carried.

Delegates

ALACHUA — O. Frank Agee, M.D.; Thomas D. Bartley, M.D.; William B. Deal, M.D.; William T. Hawkins, M.D.; Douglas O. Jenkins, M.D.; Gerold L. Schiebler, M.D.; Diane Zabak — Student Delegate

BAY — Philip Cotton, M.D.; James D. Nixon, M.D.

BREVARD — Richard N. Baney, M.D.; Michael J. Foley, M.D.; Brian P. Gibbons, M.D.; Howard W. Pettengill, M.D.; Francis S. Pooser, M.D.; Robert J. Sarnowski, M.D.

BROWARD — Robert L. Andreae, M.D.; Leroy G. Appell, M.D.; Leonard C. Bass, M.D.; Anna M. Blenke, M.D.; Donald A. Bolt, M.D.; Robert J. Brennan, M.D.; Phillip A. Caruso, M.D.; Milton P. Caster, M.D.; David A. d'Alessandro, M.D.; Burns A. Dobbins, M.D.; Arthur L. Eberly, M.D.; Kenneth H. Farrell, M.D.; Paul A. Flaten, M.D.; Stanley S. Goodman, M.D.; Theodore W. Hahn, M.D.; William C. Hartley, M.D.; Jerry D. Moore, M.D.; James V. Redd, M.D.; Thomas F. Regan, M.D.; Joseph M. Sachs, M.D.; Peter A. Tomasello, M.D.; Anthony J. Vento, M.D.; Harry B. Weinberg, M.D.; Wilbur F. Helmus, M.D.; David C. Lane, M.D.; George P. Messenger, M.D. (Absent — Ernest Costantino, M.D.)

CAPITAL — Robert P. Johnson, M.D.; Nelson H. Kraeft, M.D.; Robert N. Webster, M.D.; Jack W. MacDonald, M.D.

CHARLOTTE — Thomas Civitella, M.D.; Charles H. Wingo, M.D.

CITRUS-HERNANDO — W. Randall Jenkins, M.D.; Clinton J. McGrew, M.D.

CLAY — Charles T. Dellinger, M.D.

COLLIER — Nicholas H. Kalvin, M.D.; Virgil A. Ponzoli Jr., M.D.; Joseph F. Sullivan, M.D.

COLUMBIA — Barney E. McRae, M.D.

DADE — Armando F. A. Abadin, M.D.; Edward Annis, M.D.; Jerome Benson, M.D.; Jose S. Bocles, M.D.; Rufus K. Broadaway, M.D.; Luis Cabrera, M.D.; Manuel L. Carbonell, M.D.; Edmund Cava, M.D.; Jack Q. Cleveland, M.D.; Vincent P. Corso, M.D.; O. William Davenport, M.D.; Joseph H. Davis, M.D.; Charles A. Dunn, M.D.; Franklin J. Evans, M.D.; Miguel Figueroa, M.D.; N. Ralph Frankel, M.D.; George R. Gage, M.D.; Julian H. Groff, M.D.; Joseph Harris, M.D.; Walter Jones, III, M.D.; Robert B. Katims, M.D.; Norman M. Kenyon, M.D.; Melvin A. Klein, M.D.; Norman R. Korman, M.D.; Banning G. Lary, M.D.; Warren Lindau, M.D.; Carlos G. Llanes, M.D.; Simon E. Markovich, M.D.; Roberto Maury, M.D.; Burton T. Meadows, M.D.; Moises Mitriani, M.D.; Richard D. Miller, M.D.; Charles A. Monnin, M.D.; Joseph T. Ostroski, M.D.; Jorge R. Pena, M.D.; Pedro A. Ramos, M.D.; Walter M. Sackett, M.D.; Oscar Sandoval, M.D.; Janice K. Sherwood, M.D.; Everett Shocket, M.D.; S. William Simon, M.D. David Sims, M.D.; Margaret C. S. Skinner, M.D.; Leonard S. Sommer, M.D.; Chauncey M. Stone, M.D.; David J. Talarico, M.D.; Charles F. Tate, M.D.; John C. Turner, M.D.; Thomas B. Turner, M.D.; Edgar W. Webb, M.D.; Harold H. Weiner, M.D.; Steven Weissberg, M.D.; Sheldon Zane, M.D.; Robert Marema — Student Delegate (Absent — Miguel A. Mora, M.D.)

DESOTO-HARDEE-GLADES — (Absent — Calvin W. Martin, M.D.)

DUVAL — Mohamed H. Antar, M.D.; James L. Borland, M.D.; James N. Burt, M.D.; Doris N. Carson, M.D.; Yank D. Coble, M.D.; Clyde Collins, M.D.; Patricia C. Cowdery, M.D.; Richard C. Dever, M.D.; Emmet F. Ferguson Jr., M.D.; Walter G. Jarrell, M.D.; John F. Lovejoy Jr., M.D.; Charles B. McIntosh, M.D.; Faris S. Monsour, M.D.; John A. Rush, M.D.; Guy T. Selander, M.D.; Robert H. Threlkel, M.D.; James W. Walker, M.D.; William D. Walklett, M.D.

ESCAMBIA — Robert H. Cohan, M.D.; Eric F. Geiger, M.D.; Charles H. Kahn, M.D.; Charles F. McConnell, M.D.; Robert K. Wilson, M.D.; Henry M. Yonge, M.D.

FLAGLER — John M. Canakaris, M.D.

FRANKLIN-GULF — (Absent — Joseph P. Hendrix, M.D.)

HIGHLANDS — (Absent — Donald C. Hartwell, M.D.; Robert T. Rengarts, M.D.)

HILLSBOROUGH — Richard A. Bagby, M.D.; Francis C. Coleman, M.D.; Richard G. Connar, M.D.; Irving M. Essrig, M.D.; John C. Fletcher, M.D.; Thomas H. Greiwe, M.D.; Victor H. Knight, M.D.; Thomas E. McKell, M.D.; John K. Petrakis, M.D.; Michael J. Pickering, M.D.; Ronald L. Seeley, M.D.; William W. Trice, M.D.; James A. Winslow, M.D.; Deborah Bradley — Student Delegate (Absent — Ralph E. Rydell, M.D.)

INDIAN RIVER — Donald L. Ames, M.D.; Ferdinand F. Becker, M.D.

LAKE — Frederick C. Andrews, M.D.; Robert Hux, M.D.

LEE — Cecil C. Beehler, M.D.; Larry P. Garrett, M.D.; John S. Hagen, M.D.; Francis L. Howington, M.D.; H. Quillian Jones Jr., M.D.

MADISON — (Absent)

MANATEE — Thomas R. Busard, M.D.; Arthur J. Cohen, M.D.; Julian J. Giraldo, M.D. (Absent — Salvatore J. Cantolino, M.D.)

MARION — C. Brooks Henderson, M.D.; Samuel L. Renfroe, M.D.

MARTIN — Fred S. Carter, M.D.; James A. Gray, M.D.

MONROE — Robert D. Carraway, M.D.; Ronald H. Chase, M.D.

NASSAU — (Absent — Jose L. Castillo, M.D.)

OKALOOSA — David R. Arrowsmith, M.D.; Eugene R. Valentine, M.D.

ORANGE — Edward Ackerman, M.D.; Francis M. Coy, M.D.; Clarence M. Gilbert, M.D.; Wm. Edward Hoffmeister, M.D.; David L. Mackey, M.D.; Joseph G. Matthews, M.D.; Franklin B. McKechnie, M.D.; Hector R. Mendez, M.D.; Louis C. Murray, M.D.; James F. Richards Jr., M.D.; Thomas G. Sawyer, M.D.; Edward W. Stoner, M.D.; T. Byron Thames, M.D.; Robert B. Trumbo, M.D.

OSCEOLA — George A. Gant, M.D.

PALM BEACH — Vernon B. Astler, M.D.; Richard C. Cavanagh, M.D.; John D. Corbit, M.D.; Gabino S. Cuevas, M.D.; Lee A. Fischer, M.D.; J. Russell Forlaw, M.D.; Luis R. Guerrero, M.D.; James M. Johnson, M.D.; V. A. Marks, M.D.; Benjamin Moore, M.D.; Reginald J. Stambaugh, M.D.; Ben R. Thebaut Jr., M.D.; Dick L. Van Eldik, M.D.

PANHANDLE — Herbert E. Brooks, M.D.; James T. Cook Jr., M.D.

PASCO — (Absent — Robert D. May, M.D.; Morris L. Saperstein, M.D.)

PINELLAS — William W. Atkinson, M.D.; Thomas S. Daniel, M.D.; Robert L. Dawson, M.D.; Charles K. Donegan, M.D.; John M. Hamilton, M.D.; Kay Knight Hanley, M.D.; David S. Hubbell,

M.D.; Harold L. Ishler Jr., M.D.; Morris J. LeVine, M.D.; Jack A. MaCris, M.D.; Donald G. Nikolaus, M.D.; Rex Orr, M.D.; David T. Overby, M.D.; Frederick O. Smith, M.D.; Walter H. Winchester, M.D.

POLK — Howard M. DuBose, M.D.; John W. Glotfelty, M.D.; Woods A. Howard, M.D.; Thomas E. McMicken, M.D.; James D. Morgan, M.D.; Paul A. Tanner Jr., M.D. (Absent — Saul B. Gerber, M.D.)

PUTNAM — Roy E. Campbell, M.D.

ST. LUCIE-OKEECHOBEE — William H. Meyer Jr., M.D.; Richard Stern, M.D.

SANTA ROSA — (Absent — William N. Watson, M.D.)

SARASOTA — John N. Carlson, M.D.; Samuel E. Kaplan, M.D.; Kenneth C. Keihl, M.D.; Franklin Pfeiffenberger, M.D.; Richard C. Rehmeyer, M.D.; Karl R. Rolls, M.D.

SEMINOLE — Luis M. Perez, M.D.; Frederick J. Weigand, M.D.

SUWANEE-HAMILTON-LAFAYETTE — (Absent)

TAYLOR — John H. Parker, M.D.

VOLUSIA — William R. Jones, M.D.; Frank J. Lill, M.D.; Beatrice T. Silverman, M.D.; Alvin E. Smith, M.D.; Charles A. Stump, M.D.; (Absent — Charles R. DeArmas, M.D.)

WALTON — (Absent — Howard F. Currie, M.D.)

WASINGTON — (Absent — John T. Grace, M.D.)

SPEAKER OF THE HOUSE — Sanford A. Mullen, M.D.

VICE SPEAKER OF THE HOUSE — James B. Perry, M.D.

Dr. Mullen requested Dr. Richard S. Hodes, President, come to the podium to present the Distinguished Layman Award.

Distinguished Layman Award
Mr. Bert Muller

Whereas, Mr. Bert Muller of St. Petersburg, Florida, laid aside his professional career and has devoted the past 23 years of his life to serving as a professional leader and teacher for retarded children; and

Whereas, Mr. Muller who became involved on a family level, has brought about major changes in the lives of thousands of other mentally retarded persons by his actions and leadership while serving as President of the Pinellas Association for Retarded Children and as President of the Florida Association for Retarded Children; and

Whereas, He is credited as the father of Florida's PKU legislation which provides testing at birth where identification can be made of a rare form of mental retardation, allowing steps to be taken to limit its effects; and has been honored by United Commercial Travelers for "outstanding service to the mentally retarded in the State of Florida"; and

Whereas, Mr. Muller, not being content with his general education, did seek further knowledge by taking courses at the Columbia University School of Public Health, a day care seminar at the University of Alabama, management skills for voluntary health agencies at the University of Florida and an executive training seminar in mental retardation at the University of Wisconsin; and

Whereas, This man created community involvement and caused to be built a new school for mentally retarded, serves in the position of Executive Vice President of PARC and has seen his early responsibility of caring for 11 children expand to providing comprehensive programs for over 200 mentally retarded persons daily; therefore be it

RESOLVED, That with the recommendation and full support of the Pinellas County Medical Society, and by unanimous vote of the Board of Governors, the Florida Medical Association at its 106th Annual Meeting at Hollywood, Florida, May 7-11, 1980, present to Mr. Bert Muller its Distinguished Layman Award.



Mr. Bert Muller, St. Petersburg (left) receives from FMA President Richard S. Hodes, M.D., FMA's Distinguished Layman Award. Mr. Muller was cited for his dedication and work on behalf of retarded citizens.

Mr. Muller expressed his appreciation for the award and pledged to continue his efforts in serving his community in working with the mentally retarded.

Dr. Hodes presented the Annual FMA Awards for Excellence in Medical Journalism to the following:

Since the inception of the contest in 1977, the rules have allowed for special awards outside of the established categories. This year, for the first time, such an award is being given. It is presented upon recommendation of a county medical society after review by the President. Known as the President's Plaque for Community Service, the first recipient is Mr. Steve Rothman of *The Palm Beach Post Times* for his column "Medical Notes".

In the category designated for television we have declared co-winners, Scott Sobel of WFLA-TV for his report on laser surgery. Sharing the honor is Art Carlson of Miami's WPLG-TV for a presentation on strokes and useful therapy thereafter.

In the category designed to recognize outstanding journalists in radio, Marshall Tanner of WVOJ-AM for the report "Marijuana, Is It Really Harmful?"

In the category of Newspapers with circulation under 50,000, Ms. Andrea Brunais of *The Tampa Times* for her informative series on cancer prevention.

In the category of Newspapers with circulation over 50,000, Mr. Pat Malone of *The Miami Herald,* for several articles written during the past year dealing with health care.

Dr. Hodes called on Dr. Vernon Astler, Chairman of the Florida Insurance Reciprocal, to give a report to the delegates. Dr. Astler stated that the Reciprocal is very viable and serving its purpose, and presently insures approximately 6,500 physicians. Dr. Astler expressed his



Mr. Steve Rothman (left), a reporter for the Palm Beach Post, receives from FMA President Richard S. Hodes, M.D., the President's Plaque for Community Service. It was the first such award given in conjunction with FMA's medical journalism awards. Mr. Rothman was nominated by the Palm Beach County Medical Society.

concern over the increase in the amount of claims, which have doubled in the last 4½ years, and in the increased settlement costs. He stressed the importance of physicians encouraging their legislators to pass the Recovery of Costs legislation now being considered in the Florida Legislature. Dr. Astler informed the House that the Life Insurance Company, approved by the House last year, is expected to receive its license very soon.

Dr. Mullen, Speaker, called on Dr. Richard Hodes, President, to come to the podium to present the Certificate of Merit and Certificate of Appreciation.

Dr. Hodes requested Dr. James Cook and Dr. Thomas Bartley to escort Dr. Henry Babers to the podium to receive the Certificate of Merit.

Certificate of Merit
Henry Jennings Babers, M.D.

Whereas, Henry Jennings Babers, M.D., has served mankind as a dedicated physician and as an active leader in community affairs; and

Whereas, Dr. Babers has devoted his life's work to improving the quality of living to his native Gainesville, where he was born May 11, 1912, and graduated from the University of Florida before taking his Medical Degree at Cornell University; and

Whereas, He has skillfully and cheerfully filled the many roles assigned to him in organized medicine, such as President of the Alachua County Medical Society, President of the Florida Medical Association, and President of the Florida Association of General Surgeons; and

Whereas, He has served professionally as head of the department of surgery of Alachua General Hospital, Chief of Staff of the same institution, and clinical assistant in surgery at the University of Florida College of Medicine, and as a Lieutenant Colonel in the U.S. Army Medical Corps, as Commander of the U.S.E.D. Hospital in Bermuda and Chief of Surgical Services for the 179th General Hospital; and

Whereas, Dr. Babers has devoted a majority of his free time for the past several years working as a member of the Advisory Board for the University of Florida College of Medicine and as a trustee of the North Florida Regional Hospital; and

Whereas, He has involved himself in community affairs as a member of the Board of Directors of the Chamber of Commerce, a member of Rotary, Kappa Sigma Fraternity, and as a member of the Board of Deacons of the Baptist Church; therefore be it

RESOLVED, That Certificate of Merit, the highest award of the Florida Medical Association, be presented to Henry Jennings Babers, M.D., as a token of respect and affection for his accomplishments from the officers, members and staff of the Association.

Dr. Babers expressed his appreciation and pleasure in receiving this honor from the Association.

Dr. Hodes announced that Howard V. Weems, M.D., of Sebring would be awarded the Certificate of Appreciation for his many contributions to medicine. Dr. Weems was not able to be present to accept the certificate.

Certificate of Appreciation
Howard V. Weems, M.D.

Whereas, Howard V. Weems, M.D., of Sebring has devoted his lifetime. to ministering to the needs of the citizens of Sebring and



Henry J. Babers, M.D., Gainesville (center) receives from House Speaker Sanford A. Mullen, M.D., the Certificate of Merit, the highest honor FMA can bestow on a member. Looking on are FMA President Richard S. Hodes, M.D. (left), and Executive Vice President W. Harold Parham, D.H.A. Dr. Babers was President of FMA in 1969.

Highlands County, including the delivery of over 8,000 babies by actual count; and

Whereas, While working from a rented office, he did design and build Sebring's first hospital in 1926 and later increased it in size by moving out of his adjoining home to add it to the hospital, while administering the facility, performing surgery, making hospital rounds twice a day and keeping long office hours; and

Whereas, This gracious and intelligent physician saw the need, long before it was required, for continuing medical education and availed himself and his patients of such knowledge by constantly reading medical publications late at night and seeking new courses of instruction at the various medical schools; and

Whereas, His vision and foresight led him to reach out and offer employment to blacks in the community, while telling them to dream and work to make their dreams come true; and

Whereas, His dedication to the practice of medicine has been matched only by his devotion to his faith and church, including keeping a Bible in the waiting room of his office, giving away copies to his patients and urging them to read it for help and guidance; and

Whereas, Dr. Weems was a founding member of the Sebring Rotary Club in 1924 and is the only charter member still attending meetings, was the club's President in 1933-34 and received the Paul Harris award in 1974; and

Whereas, His community involvement was so broad as to include serving as a trustee of the First United Methodist Church, working with the Chamber of Commerce, contributing time and talent to the Boy and Girl Scout organizations from whom he received numerous awards of recognition; and

Whereas, He made house calls anytime, day or night, and served as the railroad's doctor, meeting passenger trains to treat sick patients regardless of the hour; now, therefore be it

RESOLVED, That the Florida Medical Association, its Board of Governors, officers, members and staff do show a token of the esteem and affection they individually and collectively hold for Howard V. Weems, M.D., by bestowing upon him the Florida Medical Association Certificate of Appreciation.



The fleet-footed McConnell Family of Pensacola was the talk of the Annual Meeting after all four family members participated in the Second Annual FMA Health Run. The head of the household, C. Fenner McConnell, M.D., not only finished first in his age group (45-49) but bested all participants by finishing the 3.1-mile course in a rapid 17:44. Wife Shirley (left) was second among females in the same age group. Nineteen-year-old Carolyn (second from left) was timed at 25:02, just one second better than sister Flora, 16 (second from right).

Dr. Mullen, Speaker, requested Dr. Francis Coleman, President of FLAMPAC, come to the podium to give a report to the delegates. Dr. Coleman reported that the membership in FLAMPAC was approximately 3,579 and stressed the importance of physicians and their spouses to belong to FLAMPAC, stating that it is a means to compete in the political process. Dr. Coleman also stressed the importance of the Recovery of Costs bill now under consideration by the Florida Legislature to FLAMPAC and the Florida Medical Association. He asked that physicians send a telegram to their representatives asking them to support House Bill 1133.

At the request of the Speaker, Dr. Francis Coleman, Chairman of the Council on Legislation, reported on various issues being considered by the Florida Legislature. Dr. Coleman urged all physicians to send telegrams to members of the House Insurance Committee asking them to support the Recovery of Costs bill, HB 1133. Dr. Coleman stressed the importance of this bill and requested that Representatives be contacted immediately.

Dr. Mullen, Speaker, requested Dr. James Perry to come to the podium to report the results of the Health Run. Dr. Perry announced the following:

1980 Health Run Winners

1st Place	C. Fenner McConnell, M.D.	17:44
2nd Place	Joe Kudyba	19:04
3rd Place	Victor P. Krestow, M.D.	19:11

First Place by Age Groups

50 & over	Victor F. Doig, M.D. (No ladies entered)	19:40	(51)
45-49	C. Fenner McConnell, M.D.	17:44	(45)
	Shirley McConnell	38:09	(45)
40-44	Joe Kudyba	19:04	(41)
	Madeleine Lill	26:49	(43)
35-39	Alan M. Silbert, M.D.	19:25	(35)
	Kathleen Rydell	30:35	(38)



They're off and running! Nearly 100 runners participated in the Second Annual FMA Health Run.

30-34	Lee A. Fischer, M.D.	22:27	(34)
	Fran Guy	22:39	(33)
25-29	(No men entered)		
	Christine Wilson	24:44	(28)
20-24	Stanley Pizzitola	24:38	(22)
	Patrice Womble	28:20	(24)
15-19	Ron Schoenbaum	19:43	(15)
	Carolyn McConnell	25:02	(19)
11-14	Ted Lescher	23:08	(12)
	Carol Ann Epstein	27:16	(11)
8-10	Michael J. Schram	23:40	(8)
	Zeina Antar	24:22	(9)

7 & under (None entered)

The Speaker and Vice Speaker had been asked to reverse the order in which the Reference Committees will present their reports, beginning with Reference Committee IV, then continuing with Committees I, II, III and V. This is being done because of current legislative developments occuring with regards to the Recovery of Costs legislation being considered by the Florida Legislature.

Dr. Mullen requested that members of Reference Committee IV come to the podium to give their report.

Report of Reference Committee No. IV Legislation and Miscellaneous

Dr. Guy T. Selander, Chairman, and his Committee came forward to present the report of the Reference Committee No. IV, Legislation and Miscellaneous.

The Reference Committee reported that each item referred to it had been considered and testimony was heard from members of the FMA regarding the issues. Information given by Mrs. Nancy Moreau, Legislative Analyst of the FMA Capital Office, was particularly helpful and enlightening.

The Committee publicly commended Dr. Coleman for his outstanding work in his role as Chairman of this Council. Furthermore, the Committee gave recognition to Mr. Donald S. Fraser Jr., Director of Legislative Affairs; Mr. George S. Palmer Jr., Manager of the FMA Capital Office; Mrs. Nancy Moreau, Legislative Analyst of the FMA Capital Office; Mr. Phil Gilbert, Director of Government Programs, and all other FMA staff members who have worked on our legislative program for outstanding service. The Committee also recognized the contributions of all members of the Florida Medical Association who participated in FMA legislative activities during the past year.

Report D of the Board of Governors

The motion of the Reference Committee to correct Report D, in the first item under "Support," by changing "State Board of Medical Examiners" to read "Department of Professional Regulations" carried.

The motion of the Reference Committee carried to delete the words "other than use for diagnostic purposes" in the seventh item under "Opposition".

The motion that a period be placed after the word "drugs" in the second item under "Endorsed" and the rest of the item deleted carried.

The motion of the Reference Committee that the entire problem of the abuse of Class II drugs be referred to the Board of Governors for study and recommendation carried.

The motion of the Reference Committee that Report D of the Board of Governors be adopted as amended carried.



Reports and resolutions in the Legislation and Miscellaneous category were reviewed by Reference Committee No. IV. Left to right: Virgil A. Ponzoli, M.D., Naples; Pedro A. Ramos, M.D., Miami; Reginald J. Stambaugh, M.D., West Palm Beach; Guy T. Selander, M.D., Chairman, Jacksonville; Ms. Dianne Fimbrez, Recorder, Jacksonville; and Victor H. Knight Jr., M.D., Tampa.

Report D of the Board of Governors

Richard S. Hodes, M.D., Chairman

Board Actions of Major Importance

1. Recovery of Costs in Civil Proceedings — The Florida Supreme Court on February 28, 1980 declared Florida's Medical Mediation Panel Statute unconstitutional. The Court's ruling set aside the medical mediation statute enacted as part of the FMA sponsored professional liability insurance reform package during the 1975 Session of the Legislature. The Court ruled it unconstitutional because "application of its rigid jurisdictional periods has proven arbitrary and capricious in operation, yet the act cannot be remedied by enlarging the jurisdictional periods or in permitting continuances or extension of time for to do so would constitute a denial of access to the Courts." The Court further rules conclusively "we are left then with a statute which is intractably and incurably defective and therefore, hold that Section 769.44 Florida Statutes (79), The Medical Mediation Act, is unconstitutional in its entirety as violative of the due process clauses of the United States and Florida State constitutions." This closes the door on remedial legislation of this nature in the future.

Your Chairman, on the day of the Court's ruling, noted that the unfortunate decision would no doubt aggravate an already developing crisis situation in malpractice insurance as evidenced by the serious rise both in claims reported since 1976 and in the average cost per claim during that same period. He further noted that the Court's action attaches even greater importance to the enactment of legislation being sponsored by the FMA during the 1980 Session of the Legislature that will provide for recovery of costs to the prevailing party in any civil proceedings. This number one legislative priority additionally provides that attorneys' fees are not to be awarded against a party that is insolvent or proverty-stricken and, in addition, provides that each attorney before initiating a civil proceeding on behalf of his client shall inform the client in writing as to the provisions of this law.

The Florida Physicians' Insurance Reciprocal's premiums and reinsurance rates and the rates for other malpractice insurance in Florida was based, in good faith, on this legislation adopted by the Legislature in 1975 and upheld by the Supreme Court twice. Without substantial legislation being passed in 1980, increases in premiums in 1981 are inevitable.

The Board has directed the highest priority be established and plans to utilize every reasonable asset to bring about the enactment of this legislation for recovery of costs in civil proceedings.

FMA Councils and Committees

COUNCIL ON LEGISLATION

1979 Legislative Session — The Council on Legislation and all those who participated in the 1979 Legislative program were commended for their significant achievement in all major legislative objectives. Special commendation was extended to Dr. James Perry for his outstanding efforts during his tenure as Chairman of the Council. A summary of the accomplishments during the 1979 Session is included in the Annual Report of the Council on Legislation.

1980 Legislative Priorities — Key issues to be addressed during the 1980 Session of the Florida Legislature were approved:

Recovery of Costs — The Board directed that the Association establish as its highest priority during the 1980 Legislative Session the enactment of legislation to provide for recovery of costs in civil proceedings and that every reasonable asset be utilized to bring about passage of this legislation. The bill, which will be sponsored by the FMA, provides that in all civil proceedings that attorney's fees will be paid to the prevailing party except in cases when the party is insolvent or poverty stricken. In addition, before initiating a suit in behalf of a client, every attorney must inform his client in writing as to the provision of this bill. Passage of this legislation is vital in the face of imminent malpractice claims which are now being faced in Florida as a result of the Florida Supreme Court's action on February 28, 1980, in declaring the medical mediation panel statute as unconstitutional. The Court's ruling closed the door on any remedial legislation to resurrect the mediation statute thus making passage of recovery of costs bill imperative to maintain stability in the medical professional liability market.

In addition to establishing recovery of costs as the number one legislative priority, the Board approved the following positions on a number of issues on health to be addressed during the Session.

Expressed "SUPPORT" for:

- Protection of physician's own medical treatment records from acquisition by investigators from the Department of Professional Regulations.
- Legislation which would reinstate the provisions that no more than two physician assistants may be supervised by any individual medical doctor and that would eliminate the ability of unlicensed medical doctors to be certified as physician assistants.
- Confidentiality of medical records.
- Reinstatement of legislation which requires preschool physicals.
- Legislation to abolish lay midwives (not certified nurse midwives).
- Legislation to repeal the law prohibiting sampling of controlled substances to physicians.
- Increased funding for physicians' services with emphasis on outpatient services in Florida's Medicaid, vocational rehabilitation, and children's medical services programs.
- Increased funding for, and improvement in, Florida's public health and mental health programs.
- Support for efforts to control the cost of medical care that is consistent with the FMA's position paper on the cost of medical care.
- Amendments to Florida Health Care Financing Act to include outpatient services rendered in physicians' offices and other appropriate ambulatory settings.
- Legislation to repeal the law prohibiting sampling of controlled substances to physicians.

Expressed "OPPOSITION" to:

- HB 349 — Triplicate prescriptions, because of the provisions which give the Florida Department of Law Enforcement overall responsibility for acquisition and maintenance of records and the fact that patient names are released to state agencies, thus violating confidentiality provisions; and further, the position of the FMA be made clear to endorse all practical means that might be taken to correct the drug problem in Florida.
- State assumption of responsibility of county health unit functions.
- Creation of state health data bank.
- SB 228 — Prohibition of referral by physicians to facilities in which they have an ownership interest.
- Certificate of Need for physicians' office equipment.
- Prescription of drugs by physician assistants.
- Prescription and administration of drugs by optometrists.
- Reporting system for physicians who have ownership in health care facilities or drug companies (truth in sickness).
- SB 283 — Mandated use by all hospital medical staffs of problem-oriented medical records.



The "old" Board of Governors gathered for one last time, and a photograph, together immediately upon adjournment of the Annual Meeting: Seated: William W. Thompson, M.D., Vice President, Fort Walton Beach; J. Russell Forlaw, M.D., Treasurer, Boynton Beach; Robert E. Windom, M.D., Secretary, Sarasota; T. Byron Thames, M.D., President-Elect, Orlando; Richard S. Hodes, M.D., President, Tampa; O. William Davenport, M.D., Immediate Past President, Miami; Louis C. Murray, M.D., Past President, Orlando; and Sanford A. Mullen, M.D., Speaker of the House, Jacksonville. Standing: W. Harold Parham, D.H.A., Executive Vice President, Jacksonville; Eugene G. Peek Jr., M.D., Advisory Member representing Florida Department of Health and Rehabilitative Services, Ocala; Walter C. Jones III, M.D., At Large, Miami; Richard G. Connar, M.D., AMA Delegate, Tampa; Thomas E. McKell, M.D., Medical District "B", Tampa; Vernon B. Astler, M.D., Florida Physicians' Insurance Reciprocal, Boynton Beach; James G. White, M.D., Medical District "C", Ormond Beach; Norman M. Kenyon, M.D., Medical District "D", Miami; and J. Lee Dockery, M.D., Medical District "A", Gainesville.

- HB 273 — Elimination of requirement for medical directors for advanced life support systems.
- Legislation to eliminate non-replacement fees for use of blood.
- Legislation to require certification for physicians who use acupuncture.
- HB 272 — Allows hospitals to be designated as medical director for advanced life support system and removes from the medical director the responsibility for the actions of paramedics.
- Legislation to further regulate the private health care community, such as certificate of need for physicians' offices.
- Efforts to dismantle, or weaken, Florida's health units and retention of local control.

"ENDORSED":

- Legislation requiring payment on an out-patient basis for surgical and diagnostic services that would be covered on a hospital in-patient basis (SB 59) providing such an act would not prohibit insurance companies from expanding out-patient coverage to include psychiatric services.
- The need for more effective control of the abuse of Class II drugs.
- HB 526 — Requirement for all health insurers to offer catastrophic health insurance plans.
- SB 95 — Exemption from liability for persons who administer required immunization to school children.
- SB 176 — Prohibits insurance companies from denying claims solely because a facility lacks surgical facilities or because it is primarily of a rehabilitative nature.
- SB 193 — Immunity from liability for volunteer physicians providing emergency care to injured athletes.
- SB 213 — Expands the time for review of various practice acts under the Florida Sunset Act and creates a permanent legislative committee to provide overview for regulatory agencies.
- HB 33 — Repeal of mandatory cervix and breast exams in non-public hospitals.
- HB 37 — Licensure of acupuncture clinics.
- HB 168 — Exemptions from liability for voluntary team physicians for elementary or secondary school athletes.
- HB 237 — Places in the statute the requirement for a five member advisory council to the children's medical services office.
- HM 307 — Establishes a special joint legislative committee to study federal regionalism.
- HM 387 — Constitutional amendment with regard to right of privacy.

The Board also expressed "SUPPORT" for:

- Florida Society of Opthalmology in its effort to defeat U.S. Congressional proposals to allow reimbursement for aphakic care by Optometrists under Medicare.
- Authorized the FMA Auxiliary to seek passage of legislation to require Florida Drivers' Licenses to contain space upon which a person may indicate gift of an organ under the provision of Florida's Anatomical Gift Act.

FMA Auxiliary — Authorized appointment of an Auxiliary representative in each Congressional District to work with the National Key

Contact Physician and County Medical Societies in carrying out the FMA's national legislative objectives.

A. Membership to county medical society legislative committees.
B. Responsibility for assisting in the physician key contact system under the supervision of the county medical society legislative chairmen.
C. Participation in the county medical society and FMA system for distribution and receipt of legislative information.

Key Contact Physician Manual — Approved the development and distribution of a legislative manual to FMA national and state legislative key contact physicians.

Council on Legislation

The Reference Committee commended Francis C. Coleman, M.D., Chairman, for his superb effort on behalf of the membership of the FMA in the field of legislation. His untiring effort benefits us all. Mrs. Nancy Moreau, Legislative Analyst, had presented information to the Reference Committee regarding legislative activities that had occurred since the preparation of the Supplemental Report of the Council on April 30, 1980.

The motion of the Reference Committee that the Report of the Council on Legislation be adopted carried.

Council on Legislation

Francis C. Coleman, M.D., Chairman

Most of the work of the Council on Legislation is accomplished through activities of its two committees: the Committee on State Legislation and the Committee on National Legislation. The report of your Council is submitted as individual reports of the two major committees.

Committee on National Legislation — This committee consists of the key contact physicians for each member of the Florida delegation of the U.S. Senate and the U.S. House of Representatives. Members of this committee have kept in close touch with their assigned senators and congressmen on national legislative matters of interest to the FMA and American Medical Association.

The Association has maintained active liaison with members of the Florida Congressional Delegation on key legislative issues. Numerous conferences in Washington between FMA staff, key contact physicians and selected congressmen were necessary in order to carry out FMA and AMA policies on these issues. In addition to these individual visits, a comprehensive visitation was conducted by FMA key contact physicians and officers with the two U.S. Senators and House members who served on committees with jurisdiction over key health issues. This continuing personal liaison resulted in excellent cooperation from Florida's delegation.

The issues that necessitated major action by the FMA and contact physicians were:

1. Carter Administration proposal on hospital cost containment (H.R. 2626).
2. Proposal to require certificate of need for physicians' office equipment.
3. Amendment to Federal Trade Commission authorization bill (S. 1991) which would prohibit preemption of state regulation of professions by the Federal Trade Commission.

The second session of the Ninety-Fifth Congress promises to be increasingly active in federal health legislation. Among the key issues that will be considered are:

1. Administration's proposal for hospital cost containment.
2. Preferential reimbursement for health maintenance organizations.
3. The national health insurance issue.

This will require the Association to continue to maintain close liaison with Florida's Congressional Delegation and with the AMA Washington Office.

Committee on State Legislation — The Committee has had another active year with responsibilities for coordinating all state legislation for the Florida Medical Association and recognized specialty groups. Four formal meetings of the committee have been held, along with informal conferences among committee members as items of an urgent nature arose.

Consistent with the policies developed by the FMA House of Delegates, the Committee has worked closely with the Board of Governors in developing our legislative program for the 1980 session of the Florida Legislature.

The following items summarize the committee's activities:

1. The legislative program is continuing to function under the supervision of Donald S. Fraser, Jr., Director of Legislative Affairs. He has been materially assisted by Mrs. Nancy Moreau, Legislative Analyst, George S. Palmer, Jr., Manager of the Capital Office and Phil Gilbert, Director of FMA Government Programs Department. Particularly helpful to the legislative activity has been the FMA Branch Offices. These have greatly increased the Association's ability to maintain liaison with county medical societies, contact physicians and members of the Legislature.
2. The Capitol Dispensary — The Committee placed major emphasis on working with the Capitol Dispensary which has proven to be most important in meeting the needs of legislators and their staffs. Mrs. Delma Hart, R.N., has continued to provide excellent assistance to the FMA in coordinating the activities of the Dispensary for the Doctor of the Day program.



Editors of *The Journal* honored retiring Editor Gerold L. Schiebler, M.D. (right) at the Annual Editor's Dinner on Wednesday, May 7. As a keepsake of his five-year term, the editors presented him with a montage depicting the five FMA presidents under whom he served and the various editors and staff who worked with him through the years. Sharing the moment is Mrs. Schiebler, as Associate Editor Clyde M. Collins, M.D., looks on.

3. The Committee on State Legislation is continuing to emphasize the need to develop a good key contact physician program in each county medical society in the state. In addition, priority attention has been directed toward increasing the role of the Auxiliary in the Association's efforts. In order to effectively accomplish this, training workshops have been carried out in each county medical society and additional workshops have been held with Auxiliary organizations.
4. Publications — A legislative bulletin was published every week during the legislative session and periodically between sessions. The bulletin is designed to give up-to-date information to members of the FMA who are involved in legislative activities. A listing of all bills monitored by the Capital Office is sent on a regular basis to county medical society executives and legislative chairmen. In addition, summaries and copies of key legislative proposals are distributed. Legislative manuals have been published and distributed to key physicians and Auxiliary leaders, and each key contact physician has been given a specially designed notebook for either state or national legislation.
5. 1979 Legislative Accomplishments — During the 1979 legislative session, there were more than 400 legislative proposals that required action by the State Legislative Committee or the Capital Office staff. Matters of major interest to the Florida Medical Association were:
   —Passage of legislation to allow attachments to standard helath insurance claim forms.
   —Clarification of law concerning functions that can be performed by a physician trained assistant.
   —Improved management and increased funding for Florida's Medicaid program.
   —Defeat of the following legislative proposals:
      —Legislation which would abolish Florida's mediation panel law.
      —Subsidies for state employees enrolled in HMOs.
      —Proposals which would establish a state health data collection system.
      —Legislation (HB 632) which would require relicensure of physicians as a condition for continuing practice.
      —Expansion of authority for unsupervised advanced nurse practitioners.
      —Increase in scope of temporary medical licensure law.
      —Proposals which would have included hospital associated physicians in the hospital cost containment bill.
6. Major Legislative Priorities for 1980 Session — The major legislative objectives, as of the date of this report, for the 1980 session of the Florida Legislature as developed by the FMA House of Delegates and the Board of Governors are:
   —Passage of proposals to:
      —Provide for the recovery of court costs and attorney fees in all civil litigation.
      —Provide for confidentiality of medical records.
      —Increase funding for, and improvement in, Florida's public health and mental health programs.
      —Increase funding for physicians' services with emphasis on outpatient services in Florida's Medicaid, Vocational Rehabilitation and Children's Medical Services Program.
      —Control the cost of medical care that is consistent with the FMA's position paper on the cost of medical care.
   —Defeat of the following legislative proposals:
      —Legislation which would dismantle or weaken Florida's public health units and retention of local control.
      —Any legislation to further regulate the private health care community, such as application of certificate of need to physicians' offices.



The Annual Editors Dinner provided some sentimental moments as the editorship of *The Journal* passed from Gerold L. Schiebler, M.D. (second from right) to Daniel B. Nunn, M.D. (left). Between Drs. Schiebler and Nunn is incoming FMA President T. Byron Thames, M.D., who appointed Dr. Nunn to the post. At far right is retiring President Richard S. Hodes, M.D., the last of five FMA Presidents to appoint Dr. Schiebler. FMA policy limits the Editor to five years in the office.

A supplemental report will be prepared by the Committee on State Legislation and distributed prior to the first session of the House of Delegates. This supplemental report will outline up-to-date progress of the FMA legislative program made during the 1980 Legislative Session. It will also include other important state legislative items which might develop prior to the FMA Annual Meeting.

The motion of the Reference Committee that the Supplemental Report of the Council on Legislation be adopted carried.

Supplemental Report
Council on Legislation and Regulations

This is to update the report of the Council on Legislation printed in the Delegates handbook. This report reflects the status of legislation as of April 29, 1980.

Legislative Status of the FMA 1980 Legislative Program

1. **Recovery of Costs (HB 1133, SB 762)** — Hearings have begun in both the House and Senate but no legislation has been reported out as of this date. HB 1133 is referred to House Insurance. SB 762 is referred to the Senate Commerce Committee.
2. **Confidentiality of Medical Records (HB 1206, SB 1069)** — HB 1206 is referred to the House Committee on HRS. SB 1069 is referred to the Senate Committees on Judiciary Civil and HRS.
3. **Increased funding for, and improvement in, Florida's public and mental health programs** — Due to the adverse impact of inflation and federal budget cutbacks, there has been no opportunity to date to improve the programming for nor funding of mental health and public health programs.
4. **Increased funding for physicians' services with emphasis on outpatient services in HRS medical programs** — Due to the budgetary situation, it appears that no increased funding will be provided by the 1980 Legislature. There is, however, a great deal of interest among House and Senate leaders in updating the physicians' fee schedule and for providing more emphasis on outpatient



Two former presidents of the FMA take time for a photograph, left, H. Phillip Hampton, M.D. (1965) of Tampa, and Leo M. Wachtel, M.D. (1960) of Jacksonville.



Mr. Kevin P. Phillips of Bethesda, Md., President of American Political Research Corp., addresses the annual Auxiliary/ FLAMPAC Luncheon.

services in HRS medical care programs. It is anticipated this will receive high priority during the 1981 Session.

5. **Support of efforts to control costs of medical care that are consistent with the FMA position paper on the cost of medical care** — To date there has been no legislative initiative taken with regard to passage of legislation as proposed in the FMA position paper on the cost of medical care.
6. **Opposition to legislation which would dismantle or weaken Florida's public health units** — Several bills have been filed in both the House and Senate (HB 1298, HB 1037, SB 875 and SB 1030) which would either provide complete state takeover of county health units or result in a serious diminishment of local involvement in these programs. The House Committee on HRS has been assigned primary jurisdiction for this issue, while the Senate HRS Committee has created a special subcommittee to study all the legislation introduced to date.
7. **Defeat of legislation which would further regulate the private health care community** — No legislation has been filed to date which would require certificate of need for purchase of physicians' office equipment. There has been no significant health regulatory legislation filed in either the House or Senate.

Status of Other Issues of Concern to Florida Physicians

A. Triplicate prescription for Class II drugs (HB 349, SB 256) — HB 349 is now in the House Appropriations Committee. SB 256 is in Senate Judiciary Criminal and Ways and Means Committees.

B. **Mandatory chiropractic services in HMOs (HB 837, SB 613)** — HB 837 is referred to House HRS Committee and SB 613 is referred to the Senate HRS Committee.

C. **Legislation to reduce requirements for medical licensure in Florida (HB 894, HB 1314, SB 418)** — Several bills have been introduced which would lower the standards for licensure of medical doctors in Florida. The House bills (HB 895, 1314) have been referred to the Committee on Regulated Industries and SB 418 is in the Senate HRS Committee.

D. **Blood Donor Legislation (HB 1066)** — HB 1066 has been referred to the House HRS Committee.

E. **Mandatory hospital staff privileges for chiropractors (HB 1292)** — Legislation has been referred to the House HRS Committee.

F. **Mandated use of problem-oriented medical records system (HB 1308, SB 283)** — HB 1308 is in the House HRS Committee and SB 283 is in the Senate HRS Committee.

G. **Licensure for Homeopathic physicians (HB 1381, SB 1051)** — HB 1381 has been referred to House HRS and Appropriations Committees and SB 1051 is in Senate HRS, Governmental Operations and Ways and Means.

H. **Licensure of lay midwives (HB 1443)** — This legislation has been referred to the House HRS and Appropriations Committees. It has received a favorable vote by the Health Subcommittee.

I. **Prohibition against seizure of medical treatment records by investigators of the DPR (HB 1533, SB 994)** — HB 1533 is referred to the House Committee on Regulated Industries. SB 994 is referred to the Senate HRS Committee.

J. **Repeal of the section requiring signs to be posted in practitioners' offices notifying procedure for consumer complaints (HB 1534, SB 649)** — HB 1534 is referred to the Committee on Regulated Industries and SB 649 is referred to the Committee on Economic, Community and Consumer Affairs.

K. **Development of records on elective surgery and opening them for public inspection (SB 478)** — This bill has been referred to the Senate HRS Committee.

L. **Elimination of the requirement for medical directors of hospices in Florida (SB 628, HB 1255)** — SB 628 is on the Senate Calendar. HB 1255 is referred to House HRS.

M. **Certification of chiropractor assistants in Florida (HB 969, SB 840)** — HB 969 has been referred to Regulated Industries and Appropriations Committees. SB 840 is in Senate HRS, Governmental Operations and Ways and Means Committees. The basic problem in this legislation is language which refers to the provision of chiropractic "medical services" by chiropractor assistants.

N. **Transfer of Children's Mental Health Services to new program office (HB 1513)** — HB 1513 is referred to the Committee on Appropriations, Subcommittee I.

O. **Elimination of the requirement for medical directors for advanced life support systems (HB 273, SB 797)** — HB 273 was amended by the Committee on HRS so it no longer contains this provision. SB 797 is referred to HRS.

P. **Re-enactment of legislation requiring preschool physicals (HB 769, SB 673)** — HB 769 is in the Education Committee and SB 673 is in Education and Ways and Means Committees.

Q. **Certification for medical doctors and other practitioners to use acupuncture (HB 44, SB 168)** — HB 44 was amended to delete the requirement for certification of medical doctors who use acupuncture. SB 168 is in Senate Governmental Operations and Ways and Means Committees.

R. **Provision for a hospital to be designated as medical director for advanced life support system (HB 272, SB 797)** — HB 272 was amended by House Committee on HRS to delete this provision and is on the House Calendar. SB 797 is referred to HRS.

S. **Cancer treatment centers (SB 1224)** — Provides for establishment of cancer treatment centers for persons under age of 21. SB 1224 has not yet been referred.

T. **Medicaid fraud control (HB 1312, SB 884)** — Contains provision giving access to M.D. office records to state Auditor General. HB 1312 has been referred to HRS and Appropriations. SB 884 is in the Senate HRS Committee.

U. **Referral to physician owned hospital (CSSB 228)** — This bill requires a physician who owns more than 3% interest in a hospital to disclose this to each patient referred. It further prohibits prolonging stay of a patient for financial gain of the physician. CSSB 228 is now on the Senate Calendar.

Other Late Developing Legislative Activities

The Council would ask for permission to introduce to the Reference Committee any item of major significance that might have arisen in the Legislature between April 29th and the time of the FMA annual meeting.

RESOLUTION 80-6
Medical Practice Act, Display of Notices/ Confidentiality/Writing of Prescriptions

Dade County Medical Association

The motion of the Reference Committee that Resolution 80-6 be adopted carried.

RESOLUTION 80-6

Medical Practice Act
Display of Notices/Confidentiality/Writing of Prescriptions

RESOLVED, That the Florida Medical Association opposes and accordingly challenges these Provisions in the Medical Practice Act and the Department of Professional Regulation Act that appears to be unconstitutional and/or discriminatory, namely, the posting of signs in offices, the issue of confidentiality in obtaining physicians personal medical records, the restriction of writing prescriptions for office use and the unnecessary addition of the Department of Professional Regulations over the Professional Boards, by whatever legislative or legal remedies necessary.

The Chairman expressed, on behalf of the Committee, its deep appreciation to Ms. Dianne Fimbrez who performed so admirably as its recorder. The Committee also thanked all members of the Florida Medical Association who appeared before the Committee. Special thanks was given to Dr. Francis Coleman, Chairman of the Council on Legislation, and to Dr. Joseph C. Von Thron, the AMA Delegate who served as an advisor. Dr. Selander expressed his appreciation to the members of the Committee for their outstanding service.

The motion of the Reference Committee that the report of Reference Committee IV be adopted carried.

The Speaker resumed the Chair and called for the report of Reference Committee No. I.



G. Douglas Talbott, M.D., of Smyrna, Ga., Director of Georgia's Disabled Doctor Program, presented a "Special Program on Impaired Physicians." With Dr. Talbott is Mrs. B. David Epstein, President of the FMA Auxiliary which co-sponsored the program.

Report of Reference Committee No. I Health and Education

Dr. H. Quillian Jones Jr., Chairman, and his committee came forward to present the report of Reference Committee No. I, Health and Education.

Report B of the Board of Governors

The Reference Committee noted that the first line of Recommendation No. B-1 should read "FMA" not "AMA".

The motion of the Reference Committee to adopt Recommendation No B-1 as amended carried.

The motion of the Reference Committee to adopt Recommendation No. B-2 carried.

The motion of the Reference Committee that Recommendation No. B-3 of the Board Report be adopted with the addition of the "Florida Society of Physical Medicine and Rehabilitation" carried.

The motion of the Reference Committee that Recommendation No. B-4 be amended to grant a six month extension for the groups and that the Florida Society of Physical Medicine and Rehabilitation be deleted from the recommendation carried.

The motion of the Reference Committee that Report B of the Board of Governors be adopted as amended carried.

Report B of the Board of Governors

Richard S. Hodes, M.D., Chairman

Board Actions of Major Importance

1. Continuing Medical Education — The House of Delegates at its meeting in 1977 adopted Resolution 77-19, Continuing Medical Education Records, which directed that the FMA develop as soon as practical and feasible an appropriate centralized computer system in the FMA Headquarters for monitoring CME records.

The Board has evaluated a number of centralized CME systems and their cost of operation. The Board has also reviewed the appeal and suspension procedures for the CME program.

The Board has approved a centralized and computerized CME program for the FMA similar to that of the Pennsylvania Medical Society with reporting forms to be processed directly by the FMA. Delinquencies will be sent to the county medical societies for review and return to FMA. The Board also approved modification of the CME suspension and appeals procedures to provide for a delinquent date of April 1 and a suspension date of October 31, unless compliance is demonstrated by that date.



H. Quillian Jones Jr., M.D., Fort Myers, chaired Reference Committee No. I (Health and Education). Pictured (left to right): Richard B. Moore, M.D., West Palm Beach; Barney E. McRae, M.D., Lake City; Mrs. Joyce DeMatteis, Recorder, Jacksonville; Dr. Jones; Irving M. Essrig, M.D., Tampa; and Jerome Benson, M.D., Miami.

Under the modified procedures, all physicians who were delinquent as of December 31, 1979, and subject to suspension March 15, 1980, are granted an extension until October 31, 1980, to satisfy their CME requirements.

The Board further directed that county medical societies be advised that while a budget provision has been made for implementation of this program, cost factors may necessitate a dues increase.

2. AMA CME Accreditation — The Board reviewed the actions of the AMA House of Delegates in July 1979 in withdrawing from the Liaison Committee on Continuing Medical Education (LCCME) and resumption by the AMA of administering CME accreditation activities. The FMA has subsequently received correspondence directly from the LCCME regarding that group's continued CME activities.

RECOMMENDATION NO. B-1

THAT THE FMA REAFFIRM ITS SUPPORT OF THE AMA'S CME ACCREDITATION ACTIVITIES AND FMA'S PARTICIPATION IN THESE ACTIVITIES.

FMA Councils and Committees

COUNCIL ON SPECIALTY MEDICINE

Advanced Training Programs — The Board took the position that there should be criteria established for admission to advanced medical training programs to assure that participants have the necessary qualifications to receive advanced training.

Neonate Transfers — The Board requested FMA Legal Counsel to review the subject of neonate transfer liability for an opinion on who is legally responsible when the neonate transport team has arrived at the referring hospital and has begun stabilization techniques as directed by the receiving physician.

Florida Infant Screening Program — Rules and regulations for Florida's Infant Screening Program were recently promulgated by the Department of HRS. These regulations were formulated without appropriate consultation with all interested, involved health professionals and by their intent exclude the private sector in the performance of these screening procedures.

A laboratory must screen a minimum of 50,000 annually to meet the criteria for participation. In addition, they designate the specific methodology to be used. Presently, the composition of the Department of HRS Infant Screening Advisory Council is two lay persons and seven pediatricians. The Board is of the opinion that these should be a broader representation of involved, medical specialties on the Advisory Council.

RECOMMENDATION NO. B-2

THAT THE FMA ADOPT THE FOLLOWING POSITION CONCERNING THE RECENTLY PROMULGATED RULES AND REGULATIONS OF FLORIDA'S INFANT SCREENING PROGRAM:

THE FMA SUPPORTS THE CONCEPT OF NEONATAL SCREENING FOR METABOLIC DISEASES. HOWEVER, IT DOES NOT SUPPORT THE IMPLEMENTATION OF THE RULES AND REGULATIONS AS PROMULGATED BY THE DEPARTMENT OF HRS BASED ON THE ABSENCE OF INPUT BY ALL INTERESTED AND INVOLVED HEALTH PROFESSIONALS, AND SUGGESTS THAT THE DEPARTMENT OF HRS DELAY IMPLEMENTATION UNTIL ADEQUATE INPUT IS OBTAINED.

IT IS RECOMMENDED THAT THE DEPARTMENT OF HRS ELIMINATE THE REQUIREMENT THAT A PARTICIPATING LABORATORY MUST PERFORM EACH OF THE SCREENING TESTS OF A MINIMUM OF 50,000 NEWBORNS ANNUALLY AND ONLY REQUIRE THAT ANY PARTICIPATING LABORATORY DEMONSTRATE QUALITY CONTROL, PROFICIENCY AND WILLINGNESS.

IN ADDITION, ALL PARTICIPATING LABORATORIES SHOULD BE REQUIRED TO CONFORM TO PRESENT AND FUTURE NATIONAL STANDARDS IN PERFORMING SUCH TESTS.

IT IS RECOMMENDED THAT THE DEPARTMENT OF HRS FORMULATE A MECHANISM OF PROMPT REPORTING TO IDENTIFIED RESPONSIBLE PHYSICIANS AND INSTITUTIONS IN A MINIMUM TURNAROUND TIME, AND FURTHER, THAT FLORIDA'S INFANT SCREENING ACT BE REVISED TO INCLUDE ON THE ADVISORY COUNCIL A BROAD RANGE OF SPECIALTY GROUPS INCLUDING, BUT NOT LIMITED TO, PRIVATE PRACTICING PEDIATRICIANS, PATHOLOGISTS, OBSTETRICIANS AND FAMILY PHYSICIANS.

X-Ray Certification — The Board authorized the Council on Specialty Medicine to continue its efforts to have the *Home Study Guide* for limited x-ray certification amended to cover only basic safety aspects.

Specialty Group Recognition Program — During last year's recognition program, a number of specialty groups were not in full compliance with FMA guidelines for recognition. However, they have now provided the Council the appropriate information to substantiate their compliance.

RECOMMENDATION NO. B-3

THAT THE FMA GRANT FULL RECOGNITION FOR 1979-80 TO THE FOLLOWING SPECIALTY GROUPS WHICH HAVE NOW MET ALL GUIDELINES FOR FULL RECOGNITION:

FLORIDA CHAPTER, AMERICAN COLLEGE OF CHEST PHYSICIANS
FLORIDA ENDOCRINE SOCIETY
FLORIDA NEUROSURGICAL SOCIETY
FLORIDA SOCIETY OF PLASTIC AND RECONSTRUCTIVE SURGEONS
FLORIDA THORACIC SOCIETY
FLORIDA PSYCHIATRIC SOCIETY
FLORIDA SOCIETY OF COLON AND RECTAL SURGEONS
FLORIDA OCCUPATIONAL MEDICAL ASSOCIATION
FLORIDA SOCIETY OF PHYSICAL MEDICINE AND REHABILITATION

RECOMMENDATION NO. B-4

THAT TENTATIVE RECOGNITION BE GRANTED FOR THE FOLLOWING SPECIALTY GROUPS SUBJECT TO FMA RECEIVING THE APPROPRIATE DOCUMENTATION THAT ALL GUIDELINES HAVE BEEN MET; AND THAT THE CHAIRMAN OF THE COUNCIL ON SPECIALTY MEDICINE BE AUTHORIZED TO MAKE FINAL DETERMINATION REGARDING A RECOGNITION STATUS RECOMMENDATION TO THE HOUSE OF DELEGATES REFERENCE

COMMITTEE:
FLORIDA CHAPTER OF THE AMERICAN COLLEGE OF EMERGENCY PHYSICIANS
FLORIDA STATE SURGICAL DIVISION, INTERNATIONAL COLLEGE OF SURGEONS
FLORIDA SOCIETY OF NEUROLOGY

FMA Councils and Committees

COUNCIL ON SCIENTIFIC ACTIVITIES

1980 Annual Meeting Format — The Board approved the format for the 1980 Annual Meeting to be held May 7-11, 1980, at the Diplomat Hotel, Hollywood, Florida; in keeping with the general theme of physical fitness/lifestyle and requested the Committee on Physical Fitness to arrange for a special Symposium on Physical Fitness on Thursday afternoon from 5:30-6:30 p.m.

The scientific program approved by the Board will allow physicians to earn up to 20 hours of mandatory CME credit.

CME Requirements — The Board reaffirmed existing policy that the requirements of FMA mandatory CME program be applied equally to all practicing members who are not individually exempted for unique reasons.

FMA Journal — The Board approved nominations for appointment or reappointment to the Editorial Board of the FMA Journal and Committee on Scientific Publications for the year 1980-1981.

Associate Editors

Clyde M. Collins, M.D., Jacksonville
E. Charlton Prather, M.D., Tallahassee

Assistant Editors

Edward Pedrero, M.D., Tampa
James K. Conn, M.D., Tallahassee
Lee A. Fischer, M.D., West Palm Beach



FMA Secretary Robert E. Windom, M.D., (right) engages Yank D. Coble Jr., M.D., (left) and Henry M. Yonge, M.D., in some light conversation at the Annual Dean's Luncheon. Dr. Coble is Chairman of the FMA Council on Scientific Activities, and Dr. Yonge heads the Committee on Continuing Medical Education.

Historical Editor

William M. Straight, M.D., Miami

Book Review Editor

F. Norman Vickers, M.D., Pensacola

Report of the Council on Scientific Activities

The motion of the Reference Committee that Report of the Council on Scientific Activities be adopted as printed in the Handbook carried.

Council on Scientific Activities
Yank D. Coble Jr., M.D., Chairman

In discharging its duties under the FMA Bylaws, the Council met twice: On September 14, 1979, in Gainesville, and on February 29, 1980, in Jacksonville, the latter a joint meeting with its Committee on Continuing Medical Education.

Recommendations and matters referred to the Executive Committee and the Board of Governors at intervals throughout the year and other business that commanded the Council's attention are summarized below:

Committee on Continuing Medical Education

The Committee on Continuing Medical Education continued to function efficiently and effectively under the able leadership of Henry M. Yonge, M.D., of Pensacola, a veteran member of the Committee who is completing his first year as Chairman. The Committee met in Tampa on August 17, 1979, and in Jacksonville on February 29, 1980.

1. **Annual Meeting Scientific Program:** The Committee was pleased to work with the FMA Committee on Physical Fitness and its Chairman, James B. Perry, M.D., of Fort Lauderdale, in developing the theme of "Physical Fitness" for the 106th Annual Meeting scientific program.

A two-part symposium, Thursday afternoon, May 8, and Friday morning, May 9, will be devoted to physical fitness. Also, a Thursday evening program will feature a closely related subject, the impaired physician.

There will be, in addition to the symposia, 33 scientific sections presented by 33 of FMA's 38 recognized specialty groups, four hours of Pfizer Laboratories' "Dialogue," Wyeth AutoTutors, and approximately 30 scientific and education exhibits.

For the third consecutive year, the Medical Education Committee of the Florida Medical Foundation has joined the FMA as an accredited co-sponsor and has approved the scientific program for 20 hours of AMA Category I Credit. Application has been made to the Florida Academy of Family Physicians for designation of certain elements of the program as being acceptable for Prescribed Credit.

Florida's three medical schools again have graciously agreed to co-sponsor the program.

2. **Program Approval:** The Committee's Program of reviewing and approving intrastate CME offerings for FMA Mandatory Credit continues to grow. Between March 1, 1979, and February 29, 1980, the Committee and its staff processed 366 individual applications for program approval, compared with 320 applications submitted during the comparable period of the previous year.

3. **Accreditation:** In the summer of 1979 the American Medical Association withdrew all participation from the Liaison Committee on

Continuing Medical Education. Since then, dual accreditation systems have existed nationally.

The FMA Board of Governors has decreed, quite properly, that the Association will participate in the accreditation program of the AMA.

Immediately after the AMA-LCCME split, the AMA Council on Medical Education delegated to the state medical associations unilateral authority to survey and **accredit in the name of the AMA** intrastate providers of CME.

Also, a Committee on Accreditation of Continuing Medical Education was established within the Council on Medical Education, and two Florida physicians were appointed to it, Dr. William B. Deal of Gainesville and Dr. Charles F. Tate, III, of Miami.

Accreditation activity in Florida has slackened early in the year, but as this report was prepared, more applications were pending. The Committee has taken the following accreditation actions:

A. The continuing medical education program of the South Florida Psychiatric Society was resurveyed on May 25, 1979. ACTION: Reaccreditation for four years granted.
B. The CME program of Mercy Hospital in Miami was resurveyed on May 18, 1979. ACTION: Reaccreditation for four years granted.
C. During a reaccreditation visit at the Bay Pines Veterans Administration Center on December 18, 1979, it was determined that the FMA program approval mechanism and the Florida Medical Foundation co-sponsorship program would fill the needs of the medical staff. ACTION: Accreditation was not renewed.

An initial accrediation visit at the Boca Raton Community Hospital was planned for March 28. Applications from the Watson Clinic in Lakeland, the Polk County Medical Association, the Florida Division of the American Cancer Society, and the American Hospital of Miami, are under preliminary consideration.

4. **Exemptions and Extensions:** The Committee considered the applications of 25 FMA members for individual exception to the CME requirements (extension of cycle, exemption, reduction in hours, etc.). Of these, 17 applications were approved as submitted or amended and approved, and eight were denied.

The Board of Governors asked the Council to consider whether full-time medical school faculty ought to be exempted from the FMA CME requirements. In consultation with the Committee on Continuing Medical Education, the Council voted to reaffirm present policy that all actively practicing physicians who are not otherwise exempt for unique reasons are subject to the established CME requirements for membership. Therefore, the Council recommended to the Board that the provisions and requirements of the CME program apply to all physicians equally.

5. **CME Delinquents:** County medical societies began reporting to FMA for the first time in 1979 the names of physicians delinquent in CME requirements for the three-year period ended December 31, 1978. This list included several hundred physicians in the early part of 1979, but by March of this year, it had been reduced to about 150. These are physicians who remain delinquent one year and three months beyond expiration of their cycle.

Under procedures originally adopted, these physicians were subject to suspension from the FMA and their county medical societies as of March 15, 1980. However, the Board of Governors, at its January 1980 meeting, moved back the suspension date to October 31, 1980.

The Council has asked the Board of Governors for clarification as to whether the October 31 date of suspension will apply to all subsequent cycles. If so, delinquent members will not be subject to suspension until one year and ten months have elapsed since the end date of their last cycle.

6. **Computerization:** Since the beginning of the CME program in 1974, the procedure has been for members to file their continuing medical education reporting forms with their county medical societies. The local societies evaluate the records and report to the FMA whether in their judgement the members have satisfactorily completed the FMA requirements.

Resolution #77-19 stated: "RESOLVED, That the Florida Medical Association develop as soon as practical and feasible an appropriate centralized computer system in the FMA headquarters for maintaining CME records."

The FMA Board of Governors has now authorized beginning a computerized system similar to the program used by the Pennsylvania Medical Society. Beginning with Cycle 2 physicians (cycle expiring on December 31, 1980), CME reports will be submitted to FMA rather than to the county medical societies. Reports will be evaluated in a manner yet to be determined and the fact of completion will be entered into the computer. The physician will receive a computer-generated certificate and a reminder notice about six months prior to the expiration of his next cycle.

In anticipation of the change to a centralized and computerized system, a Subcommittee on CME Record Evaluation was established within the Committee on Continuing Medical Education. This Subcommittee, headed by Dr. O. Frank Agee of Gainesville, has been working closely with the FMA staff in developing forms, procedures, etc.

7. **National Meetings:** The Committee was represented at a meeting of the National Council of State Committees of Continuing Medical Education in Washington, D.C., May 8-9, 1979, and at the AMA's Seventh Annual Conference on Continuing Medical Education for State Medical Associations and Specialty Societies in Chicago last October. The Committee also planned to be represented at the 76th Congress on Medical Education in Chicago, April 24-26.

The Committee voted to terminate its membership in the National Council of State Committees of Continuing Medical Education inasmuch as the AMA withdrawal from the LCCME (see below) renders further participation in the NCSCCME meaningless.

8. **Miscellaneous Business:** The CME Committee handled a wide array of other individual items of business during the year. In some of the more important actions, the Committee:

— Held that participation in committee activities of a Professional Standards Review Organization (PSRO) do not qualify for FMA Mandatory or Elective CME credits.
— Ruled that service on a voluntary health agency research grant committee does not qualify for Mandatory Credit.
— Reiterated Committee policy that no CME program will be reviewed and approved for Mandatory Credit retroactively.
— Ordered that sponsors of CME activities offering AAFP Prescribed or AMA Category I Credit designate in their printed programs that these offerings are **acceptable** (as opposed to **approved**) for FMA Mandatory Credit.
— Amended the CME credit structure to allow members to earn up to 10 hours of Mandatory Credit for each scientific paper written and published in a recognized journal, or for each book or book chapter written, or for research leading to publication, subject to a limit of 30 hours per three-year cycle.
— Ruled that a simple notarized statement that a physician has completed CME requirements for his cycle may not be accepted in lieu of a reporting form or acceptable CME certificate.

Committee on Scientific Publications

The Committee on Scientific Publications met in Gainesville on June 22, 1979, and at Lake Buena Vista on January 25, 1980. The Editor, Associate Editors and staff editors of *The Journal of the Florida Medical Association* met monthly and sometimes more often to

consider and dispose of the many details associated with the publication of the magazine.

1. **Change of Editors:** With the 106th Annual Meeting of the Florida Medical Association, the five-year stewardship of Dr. Gerold L. Schiebler of Gainesville as Editor of JFMA and Chairman of the Committee on Scientific Publications will expire. FMA policy prevented his reappointment. Under Dr. Schiebler's careful guidance, the JFMA has risen to new heights of excellence and prestige. The Council on Scientific Activities is confident that all members of the FMA share with it justifiable pride in JFMA's accomplishments with Dr. Schiebler at the helm.

The Council welcomes to its circle the new Editor, Dr. Daniel B. Nunn, a thoracic and cardiovascular surgeon in Jacksonville. Dr. Nunn was designated in January as the Editor-Designate and has devoted considerable time to learning the responsibilities and ramifications associated with this important assignment.

Dr. Nunn was formerly Editor of *Jacksonville Medicine*, the official bulletin of the Duval County Medical Society, and Guest Editor of JFMA's Special Issue on Thoracic and Cardiovascular Surgery published in October 1979.

2. **Special Issues:** JFMA continued its tradition of special issues: Historical Issue (August 1979), Thoracic and Cardiovascular Surgery (October 1979), Pathology (February 1980), University of Florida College of Medicine (March 1980), and Physical Fitness (April 1980).

For the fourth consecutive year, JFMA won the "Best Special Issue" award in the annual magazine contest sponsored by the Florida Magazine Association. The winner was the Special Issue on Orthopedic Surgery (January 1979). JFMA also took second place in the category with the Special Issue on Otolaryngology (September 1978).

The traditional Historical Issue will be published in August 1980, followed by a Special Issue on Family Medicine in September. The latter will be produced in cooperation with the Florida Academy of Family Physicians with C. O. Plyler, M.D., of Jacksonville, as Guest Editor.

3. **County Medical Society Bulletins:** The Committee has enjoyed a close relationship with the 11 county medical society bulletins published in Florida. For the past five years, their editors have doubled as Consulting Editors of JFMA.

Two new county society bulletins — Marion and Lee — have come to the attention of the Committee in the past year. Both newcomers submitted entries in the Third Annual Journal of the Florida Medical Association Awards Contest for County Medical Society Bulletins, the winners of which will be announced during the 106th Annual Meeting.

For the second straight year, the Committee sponsored the visit of a prominent journalism professor to a meeting of the Committee on Scientific Publications, county medical society editors and consulting editors, at Lake Buena Vista on January 25, 1980. Professor Charles G. Wellborn of the University of Florida College of Journalism and Communications presented an exhaustive critique of JFMA and county medical society publications at that meeting.

Editors of JFMA have noticed a distinct improvement in the quality of county medical society bulletins over the last year or two. They believe that FMA and the Committee have been at least partly responsible for fostering this improvement through sponsorship of visiting professors and the county bulletin awards contest.

4. **JFMA Income:** The Committee is pleased to report a substanial improvement in its advertising income for the first quarter of 1980, compared with the first three months of 1979. First quarter income was almost 75% ahead of the previous year. All 33 state journals participating in the State Medical Journal Advertising Bureau were down about 1.4% for 1980's first quarter. Only a small part of JFMA's increased advertising revenue can be attributed to a 16% across-the-board increase in advertising rates that went into effect on January 1.

Miscellaneous Business

1. **Research Committee:** One of the several functions of the Council on Scientific Activities is to review and make appropriate recommendations to the Board of Directors of the Florida Medical Foundation regarding applications for Foundation research funds. Due to a low balance in the research grant account, no applications were solicited this year.

2. **Medical Schools:** The Committee on Medical Education, once a part of this Council, was abolished by the House of Delegates in 1979. Its liaison functions with Florida's three medical schools through the deans and chairmen of the medical advisory committees were transferred to the Board of Governors. The Council has suggested to the FMA Executive Committee that some formal linkage at the Council level be considered perhaps through the appointment of the three deans to the Council.

The Council recommends continuing the annual Deans' Luncheon at the FMA Annual Meetings and the Deans' Breakfast at the Fall Board of Governors Meeting.

3. **FMF Medical Education Committee:** The Council and the Committee on Continuing Medical Education continue to maintain a close working relationship with the Medical Education Committee of the Florida Medical Foundation, Robert H. Threlkel, M.D., of Jacksonville, Chairman.

The Committee has been active on two fronts: (1) in maintaining a scientific speakers registry for the benefit of community hospitals, county medical societies and other local providers of CME and (2) in functioning as an "accredited co-sponsor" of local CME activities that are deserving of AMA Category I Credit. The Council feels this Committee should be congratulated for its excellent and useful efforts.

Report of the Council on Specialty Medicine

The Reference Committee considered the Report of the Council on Specialty Medicine and noted reference is made to a definition of "responsible supervision" for physician assistants.

The motion of the Reference Committee that its definition of "Responsible Supervision" be adopted did not carry, but was referred to the Board of Governors for further study to be reported back to the House of Delegates at its next meeting.

The motion of the Reference Committee that the Report of the Council on Specialty Medicine be adopted carried.

Council on Specialty Medicine

Dick L. Van Eldik, M.D., Chairman

The Council on Specialty Medicine held three meetings during the past year addressing several issues that were of importance to individual specialty groups as well as the entire Florida Medical Association.

To retain creditability as a specialty within the FMA, the recognition program for specialty groups was continued with slight modification for the guidelines that were developed. These modifications subsequently were approved by the Board of Governors. The guidelines for recognition of specialty groups are as follows and the recent modifications are noted in bold type:

A. That its purpose and need not be covered by an already existing

organization and must be a recognized specialty or subspecialty by the Council on Specialty Medicine;

B. That there is a sufficient number of physicians seeking the privileges of this society. **A minimum of 15 members that represent at least 50% of the eligible members for that society;**
C. That the organization must have held at least two annual meetings at which a quorum was present prior to the time of application, and must continue to have an annual meeting each subsequent year of recognition;
D. That a constitution and/or bylaws state its organizational structure, purpose and aims;
E. That the membership will abide by the "Principles of Medical Ethics" of the FMA and AMA;
F. That the organization provide continuing medical education to its members;
G. That the organization have statewide representation;
H. That 100% of the active eligible members shall be members of the FMA.

A recommendation of "full recognition" will be made for a specialty group within a 10% deviation of this requirement.

A recommendation of "provisional recognition" will be made for a specialty group that is between 10-15% deviation of this requirement. Under "provisional recognition" status members would be given two years in which to comply.

A recommendation of "probationary recognition" will be made for a specialty group that is over 15% deviation of this requirement. Under "probationary recognition" status members will be subject to annual review and must show significant progress towards compliance following the first year and full compliance by the second year.

I. That the attendance record of the Council representative will be considered at the time of recognition. **Since the recognition review is on a two-year basis, Council representatives will be required to attend four out of six meetings within the two-year period to meet the attendance requirement.**

The Council has worked closely with Dr. Coleman, Chairman of the Council on Legislation, in the development of legislative priorities and in an effort to avoid conflicts that could arise between specialty groups.

Subcommittees were appointed to resolve certain problems that were inherent in the fact that various specialty groups may have philosophical differences. Among these include standards for nuclear medicine, development of a manual and an examination to implement the law regarding x-ray safety, legal responsibility in neonate transfers, and criteria for implementing the Infant Screening Program in Florida.

The Council also carefully monitored the activities of physician extender groups, including advanced nurse practitioners, physician assistants and lay midwives.

The Council expressed concern regarding a program that one of the state's major medical centers began, to allow advanced medical training for persons with insufficient basic medical knowledge, and the Council urged that criteria be established to assure that participants in such programs possess the necessary qualifications.

An attempt was made to define "responsible supervision" for physician assistants, and we also recommended to the Board of Governors a position of opposition to physicians not licensed in Florida working as physician assistants within the state.

HMO and HSA activities were carefully monitored by the Council along with the Council on Government Programs. An attempt has been made to formulate a recommendation to include all of the children's medical services under one state agency.

Finally, the Council at the request of Dr. Hodes made recommendations to be submitted to the American Medical Association for the purpose of formulating a position which will be submitted to Congress concerning the extension of the Health Manpower Act.

All members of the Council have expressed the need for continuation of the Council on Specialty Medicine as a dynamic mechanism to resolve inter-specialty problems and this particular year it has been quite successful in carrying out this responsibility.

Report of the Florida Medical Foundation

The motion of the Reference Committee that the items on the Committee of Medical Education and Medical Student Loans in the report of the Florida Medical Foundation be filed carried. (See Report of Florida Medical Foundation, page 685).

The Reference Committee commended the FMA *Journal* Editorial Staff for their fine efforts which resulted in the publication of the Nutrition Textbook. The motion of the Reference Committee that the item on Nutrition Textbook in the Report of the Florida Medical



Newly-chosen President-Elect Sanford A. Mullen, M.D. (left) is congratulated by the losing candidate, FMA Vice President William W. Thompson, M.D.

Foundation be adopted carried. (See Report of Florida Medical Founation, page 685).

RESOLUTION 80-4
Economics Related to Cigarette Smoking
Dade County Medical Association

The motion of the Reference Committee that Resolution 80-4 be adopted as amended carried.

RESOLUTION 80-4
Economics Related to Cigarette Smoking

RESOLVED, That the Florida Medical Association aggressively pursue all avenues of educating the general public within the State of Florida as to the hazards of cigarette smoking emphasizing all facets of the high costs of this most serious but preventable medical problem, and therefore be it further

RESOLVED, That the FMA place a resolution in the AMA House of Delegates which strongly recommends the AMA to aggressively pursue all avenues of educating the public on this issue through nationwide educational programs and projects.

RESOLUTION 80-5
Death by Injection of a Lethal Substance
Dade County Medical Association

The motion of the Reference Committee that Resolution 80-5 be adopted did not carry but was tabled.

RESOLUTION 80-7
Continuing Medical Education Records
Escambia County Medical Association

RESOLUTION 80-8
Continuing Medical Education
Pinellas County Medical Society

The Reference Committee considered that in the three years' experience since the passage of Resolution No. 77-19, various county medical societies' CME record-keeping and counselling have proven effective in serving the membership well.

In view of the extensive discussion and issues raised with regard to potential loss of membership, more efficient service and influences that might be expressed at the local level, and possible cost effectiveness at the same level, it is the recommendation of the Reference Committee that further study and possible reconsideration be given to the entire matter, including the original Resolution 77-19.

The motion of the Reference Committee that Resolutions 80-7 and 80-8 be referred to the Board of Governors for further consideration carried.

RESOLUTION 80-7
Continuing Medical Education Records

[Not Adopted — Referred to the Board of Governors]

Whereas, Continuing Medical Education is a very necessary part of every physician's life; and

Whereas, Mandatory Continuing Medical Education seems logical and justified as a requirement for continued membership in the Florida Medical Association; and

Whereas, Recording of Continuing Medical Education credits on a local County Medical Society level has been most successful in the last few years; and

Whereas, Centralization of Continuing Medical Education Records at the Florida Medical Association would remove records from the local level, thereby greatly weakening the County Society's effectiveness in assuring compliance with requirements; and

Whereas, Centralization of Continuing Medical Education records at the Florida Medical Association would be an added expense in the form of higher dues to all members, but benefiting only a small segment of the Florida Medical Association members; therefore be it

RESOLVED, That the Resolution 77-19 on Centralized Computer Continuing Medical Education Records adopted by the House of Delegates at the Florida Medical Association Annual Meeting in 1977 be rescinded; and be it further

RESOLVED, That record keeping of Continuing Medical Education, with eventual transfer of records to the Florida Medical Association be continued at the local County Medical Society level, because experience demonstrates its effectiveness.

RESOLUTION 80-8
Continuing Medical Education

[Not Adopted — Referred to the Board of Governors]

Whereas, Local medical societies have been involved in continuing medical education accounting and reporting from its inception, and

Whereas, Local societies have developed methods of accurate accounting and reporting, and

Whereas, These methods isolate problem areas, they also enable the local society staff to deal with and offer assistance to members having problems in an efficient, personal manner, and

Whereas, Central and computerized continuing medical education programs could create more problems than it would solve, and

Whereas, The Pinellas County Medical Society feels any dues increase should be for a more worthwhile program, therefore be it

RESOLVED, That the accounting and reporting of continuing medical education credits not be centrally computerized, and be it further

RESOLVED, That continuing medical education accounting and reporting be left to the local societies.

The Chairman expressed his appreciation to all members of the Association who appeared at the meeting to provide guidance and counsel. Special thanks was conveyed to Dr. Richard G. Connar and Dr. William J. Dean who represented the AMA Delegates at the meeting. Dr. Jones expressed his appreciation to all members of the Committee and to the FMA staff, Mr. Edward Hagan and Ms. Joyce DeMatteis for their assistance in the preparation of the report.

The motion of the Reference Committee that Report of Reference Committee I be adopted as amended carried.

Report of Reference Committee No. II Public Policy

Dr. Roy E. Campbell, Chairman, and his committee came forward to present the report of Reference Committee No. II, Public Policy.

Report C
of the
Board of Governors

The motion of the Reference Committee that Recommendation No. C-2 be adopted as amended carried.

The motion of the Reference Committee that Recommendation No. C-5 be adopted as amended carried.

The motion of the Reference Committee that Recommendation No. C-7 be adopted as amended carried.

The motion of the Reference Committee that Recommendation No. C-8 be adopted carried.

The motion of the Reference Committee that Recommendation No. C-11 be adopted as amended carried.

The motion of the Reference Committee that Report C of the Board of Governors be adopted as amended carried.

Report C
of the
Board of Governors
Richard S. Hodes, M.D., Chairman

1979 House of Delegates Referrals

Improper Prescription Writing — While considering the Board of Governors Report concerning Allied Health Professions, the Reference Committee received a report regarding two problems dealing with the writing of prescriptions. Florida law requires:

1. If a prescription is written on a blank which does not have the name of the prescriber printed at the top, such as hospital prescription blanks the prescriber must print his name under his signature at the bottom.
2. Prescriptions for controlled substances (scheduled drugs) must be written on a single prescription blank, with no other substance prescribed on the same prescription form.

The Florida Pharmaceutical Association had notified the FMA on a number of occasions that these two regulations were not being adhered to in many instances, creating a significant problem for pharmacists in Florida. The House of Delegates referred the subject of improper prescription writing to the Board of Governors for publication in appropriate FMA communications. Pursuant to the instructions of the House, the information was transmitted to the membership through the FMA *"Briefs"* and was included in the House



Reference Committee No. II heard comments from FMA members on items of business related to public policy. Left to right: Thomas R. Busard, M.D., Bradenton; Robert P. Johnson, M.D., Tallahassee; Warren Lindau, M.D., Miami; Roy E. Campbell, M.D., Chairman, Palatka; Mrs. Irene Schmutz, Recorder, Jacksonville, and William C. Hartley, M.D., Fort Lauderdale.

of Delegates proceedings issue of *The Journal* in July.

School Health Physical Examination Form — The Board of Governors in Recommendation No. C-3 to the 1979 House of Delegates recommended that FMA endorse the school physical examination form proposed by the Committees on School Health and Sports Medicine. The form was not adopted but referred back to the Board of Governors for further consideration. This has been under continuing study by the Council on Medical Services. Much of the criticism of the previously proposed examination form came from pediatricians testifying at the Reference Committee. The Council has sought the assistance and endorsement of the Florida Pediatric Society in preparing the revised edition.

RECOMMENDATION NO. C-1

THAT THE FMA ENDORSE THE PROPOSED PRE-SCHOOL PHYSICAL EXAMINATION FORM DEVELOPED BY THE COMMITTEE ON SCHOOL HEALTH IN COOPERATION WITH THE FLORIDA PEDIATRIC SOCIETY WHICH IS INCLUDED IN THE DELEGATES' PACKETS.

Resolution 79-27 — TB Skin Testing in Jails — This resolution introduced by Dr. Van Eldik, Delegate, was not adopted but referred to the Board of Governors.

The Resolve of this resolution encouraged the use of the TB skin test as a routine procedure in county jails to detect tuberculosis in all prisoners held in custody sufficiently long to permit an intradermal skin test for TB to be performed and to take a chest x-ray on all infected individuals.

After consultation with Dr. Clifford Cole, Director of the State Tuberculosis Control Office, the FMA Public Health Committee is of the opinion that the problem of tuberculosis in local jails is serious enough to recommend the establishment of screening programs in all local jails.

RECOMMENDATION NO. C-2

THAT THE FMA RECOMMEND TO THE DEPARTMENT OF HRS AND THE DEPARTMENT OF CORRECTIONS THAT ALL PRISONERS BE SKIN TESTED FOR TUBERCULOSIS UNLESS CONTRAINDICATED UPON ADMISSION TO LOCAL JAILS AND THAT AN APPROPRIATE FOLLOW-UP X-RAY BE PERFORMED AND TREATMENT OBTAINED WHERE INDICATED.

Resolution 79-14 — Transfer of Burn Patients — This resolution, introduced by the Brevard County Medical Society, was not adopted but referred to the Board of Governors for consideration by the Council on Medical Services. The resolve of this resolution called for the FMA House of Delegates to charge the Board of Governors with the task of establishing a mechanism to enable all Florida hospitals to expedite prompt transfer of burn patients and other similar emergency conditions requiring treatment in specialized centers, without delay or consideration of finances or remuneration. The Reference Committee noted that the subject of the resolution was already under consideration by the Council.

The Council through its Committee on Emergency Medical Services is continuing its study on the subject of critical care in Florida. Presently the EMS Committee is analyzing the Survey it conducted last year to determine hospital capabilities for providing optimal care for the following categories of medical problems:

1. Major Trauma
2. Head and Spinal Cord Injuries
3. Burns
4. Cardiac
5. Neonatal
6. Psychiatric, Drug, Poison and Alcohol

In addition, the EMS Committee is currently negotiating with representatives of the Department of Health and Rehabilitative Services a proposal whereby the Department of HRS would contract with the Florida Medical Foundation for planning and development of State EMS Programs including:

A. Pre-hospital emergency medical services
B. In-hospital critical care needs and standards
C. Transfer systems and agreements
D. Determining present hospital capabilities for handling critical care patients.

Board Actions of Major Importance

1. Florida Regional Association of Blood Service Units — The Board approved FMA's participation as a member in the Florida Regional Association of Blood Service Units. Among the purposes of the organization are: a) To foster cooperation with blood programs of the Florida Association of Blood Banks and other blood service systems in promoting adequate supplies of voluntary donated blood to meet the needs of the people of Florida; b) To monitor, promote and coordinate blood service activities including collection, distribution, inventory, management and public education; c) Achieve maximum effectiveness in the procurement and distribution of blood and cooperate with other regional Associations, the American Blood Commission and other national and federal programs.

2. Florida Health Care Council — The Board approved distribution with the FMA *Briefs* an educational brochure developed by the Florida Health Care Information Council on Florida's Generic Drug Law.

3. National Health Service Corps — The Board authorized the Florida Medical Foundation to give consideration to the feasibility of contracting with the United States Public Health Service for administration of the National Health Service Corps in Florida. During the past year, some 2,200 medical students were obligated to the PHS and there has been little sensitivity to the areas in which they are placed and little consultation with local county medical societies. It is hoped that more active involvement in this program will influence the distribution of PHS physicians to areas where they are most needed and avoid current indiscriminate placement.

FMA Councils and Committees

COUNCIL ON MEDICAL SERVICES

School Athletic Injuries — For several years the FMA Committee on Sports Medicine has studied the subject of athletic injuries in school programs and has expressed to the Board the opinion that one of the most important steps that could be taken in reducing the number and severity of such injuries would be the establishment of an Athletic Trainer Program for secondary schools. Until recently there has not been much interest within the Department of Education or any other organization related to school athletic programs in addressing this subject. However, in February 1979, HEW sent a report to Congress suggesting that casualties in school athletic programs may have reached unacceptable high levels as more than a million injuries occur each year. Then HEW Secretary Califano requested that each state school official review the report to assure that local athletic programs are as safe as possible. The FMA is already on record in support of the concept of athletic trainers.

RECOMMENDATION NO. C-3

THAT FMA APPROVE IN PRINCIPLE THE PROPOSED POSITION PAPER ON INJURIES IN SCHOOL ATHLETIC PROGRAMS (INCLUDED IN THE DELEGATES' PACKET), INCLUDING THE REQUEST THAT THE FLORIDA COMMISSIONER OF EDUCATION APPOINT A STATE TASK FORCE FOR DEVELOPING AN ATHLETIC TRAINER PROGRAM IN FLORIDA.

Advanced Nurse Practitioners — The Board received a report that Advanced Nurse Practitioners may obtain a certificate to practice nursing at an advanced level simply by documenting certain additional training or educational requirements and are not required to complete a written examination.

RECOMMENDATION NO. C-4

THAT THE FMA FORMALLY NOTIFY THE BOARD OF MEDICAL EXAMINERS' THREE REPRESENTATIVES TO THE STATE BOARD OF NURSING'S ADVANCED NURSE PRACTITIONERS ADVISORY COMMITTEE THAT THE FMA HAS TAKEN THE POSITION THAT NURSES APPLYING FOR CERTIFICATION AS ADVANCED NURSE PRACTITIONERS SHOULD BE REQUIRED TO DEMONSTRATE THEIR PROFICIENCY AT AN ADVANCED LEVEL THROUGH A WRITTEN EXAMINATION WITHIN THE AREA OF THEIR SPECIALTY, TO INSURE CONTINUED QUALITY MEDICAL CARE IN FLORIDA.

Physician Assistants — The new Medical Practice Act does not contain any provision with regard to limiting the number of Physician Assistants a single physician may supervise. The previous Medical Practice Act allowed a maximum of two physician assistants per physician. The Board is concerned that this provision may result in the abuse of physician assistants. While two may be an arbitrary number, there should be some restrictions.

RECOMMENDATION NO. C-5

THE FMA FEELS THAT IT IS DIFFICULT FOR AN INDIVIDUAL PHYSICIAN TO ADEQUATELY SUPERVISE MORE THAN TWO PHYSICIAN EXTENDERS AND THEREFORE WE RECOMMEND TO THE BOARD OF MEDICAL EXAMINERS THAT SOME RESTRICTION, IN THE INTEREST OF QUALITY MEDICAL CARE, BE PLACED ON THE NUMBER OF PHYSICIAN EXTENDERS A SINGLE PHYSICIAN MAY SUPERVISE.

Prescription Writing — The Florida Academy of Physician Assistants has formally notified the FMA that the Academy will conduct a legislative program in 1980 to allow Physician Assistants to prescribe drugs from a limited formulary under the direct supervision of a physician. It is also contemplated that the Florida Nurses Association will seek a similar privilege for Advanced Nurse Practitioners.

RECOMMENDATION NO. C-6

THAT THE FMA TAKE A POSITION OF OPPOSING ANY DRUG PRESCRIBING ROLE BY ANYONE EXCEPT LICENSED PHYSICIANS, DENTISTS, VETERINARIANS, OSTEOPATHS AND PODIATRISTS AS LICENSED UNDER THE APPROPRIATE FIVE CHAPTERS OF THE FLORIDA STATUTES.

Florida Podiatry Association — The Board notified the Florida Podiatry Association that the Florida Medical Association's Relative Value Studies Committee essentially supports the Medicare Medical Allowance Rule in paying for serial surgery and therefore the FMA cannot join the Florida Podiatry Association in a challenge of the rule.

Teacher Referrals — The Board advised the Department of Education and the Health Program Office, Department of HRS, that the FMA recommends that schools should adopt a policy that in any instance where a student has been identified as having a medical problem, it should be brought to the attention of his parents for referral to his own physician or the local health department.

Tuberculosis in State Prisons — The Board received a report on a recent screening program in Florida's prison system which revealed a 25% ratio of positive reactions to a tuberculin skin test. Out of the 19,000 prisoners tested, about 1,800 have actually been placed on drug therapy for tuberculosis. The Florida Prison System releases about 6,000 prisoners per year and therefore would like to see a skin test for tuberculosis performed at the time of admission and discharge from the prison system.

RECOMMENDATION NO. C-7

THAT THE FMA RECOMMEND TO FLORIDA'S DEPARTMENT OF CORRECTIONS THAT ALL PRISONERS BE SKIN TESTED FOR TUBERCULOSIS UNLESS CONTRAINDICATED AT THE TIME OF ADMISSION AND DISCHARGE FROM THE STATE PRISON SYSTEM WITH APPROPRIATE FOLLOW-UP X-RAY PERFORMED AND TREATMENT OBTAINED WHERE INDICATED.

Body Stimulants — The Board voted to notify Akers Pharmaceutical Company of Lewistown, Pennsylvania that the FMA objects to their direct mail advertisements to Florida's teenagers promoting the use and sale of body stimulants, and considers such activity as being clearly unethical. A complaint had been received from a physician about the company sending teenagers in Florida direct advertisements promoting the use and sale of body stimulants. A check with authorities into the legality of this activity indicated that it is not in violation of any state or federal statute.

Physical Fitness Theme — County medical societies were



Joseph G. Matthews, M.D., Orlando (center), Chairman of the FMA Committee on Impaired Physicians, with G. Douglas Talbott, M.D., of Smyrna, Ga., and Mrs. B. David Epstein, Key Biscayne, President of the FMA Auxiliary. Dr. Talbott, Director of Georgia's Disabled Doctor Program, gave a program on Thursday evening.

requested to help promote this year's FMA theme on physical fitness through the sponsorship of local events.

Team Physicians — During the past year, a number of inquiries and complaints have been received from county medical societies, FMA members, and one local school board concerning non-M.D.'s serving as team physicians for school athletic programs. In an attempt to try to delineate what training is essential for the health care of the athlete, the various health practice acts were reviewed and the Board is of the opinion that chiropractors and other non-medical personnel are not adequately trained to provide care for the injured athlete.

RECOMMENDATION NO. C-8

TO APPROVE THE POSITION OF THE FMA, TRANSMITTED TO THE DEPARTMENT OF EDUCATION, THAT SCHOOL ATHLETIC TEAM PHYSICIANS SHOULD BE LICENSED TO PRESCRIBE MEDICINE AND PERFORM SURGERY IN THE STATE OF FLORIDA.

Advanced Registered Nurse Practitioners Functions — Requested that the Board of Medical Examiners study the list of Advanced Registered Nurse Practitioner Services proposed for Medicaid reimbursement (included in the Delegates' Packet) for the purpose of determining if any of these procedures are the practice of medicine and not authorized by the Nurse Practice Act.

On December 3, 1979, the Board of Nursing held a public hearing to obtain testimony from nurses regarding whether or not the listing of procedures were actual nursing functions. During this hearing, an FMA representative testified that these procedures should be reviewed by the Board of Nursing's Joint Advisory Committee which includes representatives from the Board of Medical Examiners. The Nursing Board replied that these procedures were clearly nursing functions as authorized under the new Nurse Practice Act and did not need review by the Joint Advisory Committee. A recent contact with the Board of Nursing confirmed they have no intentions of referring these procedures to the Advisory Committee. Medicaid officials have advised FMA that these procedures will be promulgated as eligible for reimbursement once the Medicaid office has officially received a verification communication from the Board of Nursing.

Advanced Registered Nurse Practitioner Supervision — Presently the Joint Advisory Committee is reviewing specific medical functions that can be performed by advanced registered nurse practitioners under protocols with a physician. However, there is no requirement for direct supervision or that the physician practice within the same community as the advanced registered nurse practitioner.

RECOMMENDATION NO. C-9

THAT THE FMA RECOMMEND TO THE BOARD OF MEDICAL EXAMINERS AND BOARD OF NURSING REPRESENTATIVES TO THE ADVANCED REGISTERED NURSE PRACTITIONER JOINT ADVISORY COMMITTEE THE DEVELOPMENT OF A RULE WHICH WOULD REQUIRE THAT ADVANCED REGISTERED NURSE PRACTITIONERS MUST BE UNDER THE DIRECT SUPERVISION OF A SPECIFIC PHYSICIAN WITHIN THE SAME COMMUNITY IN WHICH THE A.R.N.P. PRACTICES; AND FURTHER, SHOULD THE ADVISORY COMMITTEE OR BOARD OF NURSING NOT ACCEPT THIS RECOMMENDATION, THE COUNCIL STRONGLY RECOMMENDS THAT THE FMA SEEK A LEGISLATIVE REVISION THAT WOULD IMPLEMENT THE INTENT OF THIS RECOMMENDATION.

Prison Drug Abuse Programs — The Board recommended to the Department of Corrections appointment of a study commission on prison drug abuse treatment programs, and that the commission be charged with the responsibility for analyzing the costs of these programs as compared to their effectiveness or success ratio.

Juvenile Shelters — The Board requested the Department of HRS to establish a task force to study and make recommendations on health care services for dependent and delinquent children in state facilities.

Voluntary Health Agency Recognition Program — Currently the VHA Recognition Program is conducted annually which places a considerable work burden on the Council and staff. In a recent joint meeting, representatives of voluntary health agencies agreed that the program does not need to be conducted on an annual basis. However, the desire was expressed for FMA to continue some form of a periodic formal review process.

RECOMMENDATION NO. C-10

THAT THE FMA MODIFY ITS VOLUNTARY HEALTH AGENCY RECOGNITION PROGRAM SO THAT A FORMAL REVIEW OF RECOGNIZED VOLUNTARY HEALTH AGENCIES IS CONDUCTED EVERY THREE YEARS IN PLACE OF THE PRESENT ANNUAL REVIEW.

FMA Councils and Committees

COUNCIL ON SPECIALTY MEDICINE

Children's Medical Services — The Board authorized, if it becomes necessary, the FMA's formally petitioning the Department of HRS for upgrading the medical fee schedules of the Children's Medical Services Program.

Physician Assistant Supervision — Referred the following statement regarding the definition of "Responsible Supervision" for physician assistants to the State Board of Medical Examiners for consideration:

> The physician assistant is certified by the Florida Board of Medical Examiners to a licensed physician who is responsible for all the actions of the physicians assistant. The physician must, at all times, exercise responsible supervision over the activity and performance of the physician assistant.
>
> Responsible supervision means that the physician must be immediately accessible by telephone or other means of communication and that he should be able to be physically present, if necessary, within 15 to 20 minutes just as he would be when he is on duty and available to his patients in his regular practice coverage.
>
> If the responsible physician is not on duty, away from the community where he practices, ill or on vacation, the physician assistant must be under the supervision of another licensed physician covering for the responsible physician or delegated by the responsible physician to supervise the physician assistant. If no physician is available at any time to responsibly supervise the physician assistant, then the physician assistant cannot participate in patient care

Physicians Practicing as P.A.'s — The new 1979 Medical Practice Act permits physicians not licensed in Florida to work within the state as a physician assistant. The Board was advised of several newspaper reports around the state that some clinics and HMO's will meet their staffing requirements by utilizing out-of-state physicians as P.A.'s.

RECOMMENDATION NO. C-11

THAT THE FMA TAKE A POSITION OF OPPOSITION TO PHYSICIANS NOT LICENSED IN FLORIDA WORKING

AS PHYSICIAN ASSISTANTS WITHIN THE STATE; AND FURTHER

THAT THE FMA SHOULD SEEK A REVISION TO THE MEDICAL PRACTICE ACT TO ASSURE THAT THE PHYSICIAN ASSISTANT SECTION IS NOT USED AS A SUBTERFUGE FOR CIRCUMVENTING MEDICAL LICENSURE IN FLORIDA AND FURTHER

THAT THE QUESTION OF PHYSICIAN ASSISTANT RATIOS TO PHYSICIANS BE ADDRESSED.

Policy Statement on Injuries in School Athletic Programs

In February 1979, the U.S. Department of Health, Education and Welfare (DHEW) released a report on the Survey of Athletic Injuries and Deaths completed by the National Center for Education Statistics. The report cites more than a million injuries that occur each year in school and collegiate sports programs throughout the United States. The report noted that many of these injuries might have been prevented by better health care, proper conditioning, or improved equipment.

DHEW Secretary Joseph Califano forwarded copies of the report to the nation's chief state school officials and to representatives of the nation's colleges and universities, and requested that appropriate committees and organizations review the study to assure that local athletic programs are as safe as possible.

In 1976, the Florida Medical Association established a Committee on Sports Medicine to study the problem of athletic injuries in high school programs. During their deliberation the Committee made the following observations:

- A general lack of adequate medical supervision
- Need for more conditioning prior to contact work in contact sports
- Coaches need more training in medical aspects of sports
- Inadequate funding for proper safety equipment
- Presently, there is no statewide athletic injury reporting system
- The number of athletic injury legal liability suits are increasing and may eventually threaten the continuation of school athletic programs.
- Most secondary schools do not have the services of an athletic trainer.

The Committee further observed that the health care team responsible for the care of the student athlete should consist of a coach who is primarily responsible for teaching aspects; a physician who diagnoses and prescribes treatment; and an athletic trainer responsible for prevention of injuries through training techniques, keeps the coach informed on the athlete's physician condition and carries out the team physician's orders.

In most areas of Florida the missing link in the health care team for athletes is the athletic trainer who is the individual which has the most responsibility with regard to injury prevention factors.

FMA's Committee on Sports Medicine is of the opinion that one of the most important steps that could be taken in reducing the number and severity of athletic injuries within school programs in Florida is the establishment of an Athletic Trainer Program. The athletic trainer is a major cog in a complete school sports system. His primary responsibility is **prevention** of injuries, immediate first aid and rehabilitation procedures as directed by the team physician including taking care of cuts and scratches, taping and wrapping, making mouthpieces, applying ice packs, making special injury pads, physical reconditioning, planning and supervision of menus and diets, aiding in the purchase and fitting of equipment, helping to condition the athlete, and ensuring that all playing areas are free from hazards.

A number of states have already implemented a trainer program for their secondary schools. One of the more successful programs was implemented in North Carolina when a Sports Medicine Division was created within the State Department of Education and began on a modest budget of $22,500. The results of the program were so successful the budget has been increased to $60,000.

The main obstacle in obtaining the services of athletic trainers for local high schools in Florida is a lack of funding. In addition, most school administrators do not understand what a trainer does and therefore fails to recognize the need.

The Committee on Sports Medicine recently wrote to all FMA component county medical societies in Florida requesting that they become more involved in local school athletic programs and urged that each society use its influence with local school boards in bringing about the establishmnet of positions for athletic trainers at the secondary school level.

The Secretary of DHEW is correct in his statement that participation in athletics traditionally has been, as it should be, an important and valuable element in American education — intended to teach healthy competition, build character and promote physical exercise. But more attention must be paid to the toll of injuries that has accompanied sport programs.

Participation in school athletics involve shared responsibilities. The athlete's responsibilities are to play fair, keep in training and to conduct himself in a manner that will be a credit to his/her sport and school. In turn, the athlete has the right to the most optimal protection possible against physical injury through a qualified conditioning and technical instruction program, proper regulation and conditions of play, and adequate medical supervision.

The Florida Medical Association and its Committee on Sports Medicine recommends that the Commissioner of the Florida Department of Education, Mr. Ralph D. Turlington, appoint a State Task Force for the development of an Athletic Trainer Program in Florida. Such a Task Force should include representatives from the following organizations:

Florida High School Activities Association
Florida Athletic Coaches Association
Florida Congress of Parents and Teachers
Florida School Boards Association
Florida Association of School Administrators
National Athletic Trainers Association State Representatives
Florida Medical Association, Inc.
Florida Department of Education

Report of the Council on Medical Services

The motion of the Reference Committee that the Report of the Council on Medical Services be adopted as printed in the Handbook carried.

Council on Medical Services
Joseph T. Ostroski, M.D., Chairman

During this reporting period, the Council on Medical Services held two meetings and considered a broad range of subjects involving the delivery of medical care in Florida.

The Council also served as the official Advisory Committee for the American Medical Association's Jail Project in Florida. This program is administered through a contract between the AMA and the Florida Medical Foundation. It is a national program for providing technical assistance to local jails for implementing AMA standards. Presently there are twelve (12) county jails participating in this year's program:

Alachua Co. — Gainesville
Gadsden Co. — Quincy
Orange Co. — Orlando
Palm Beach Co. — W. Palm Beach

Highlands Co. — Sebring
Hillsborough Co. — Tampa
Marion Co. — Ocala
Monroe Co. — Key West
Pinellas Co. — Clearwater
Sarasota Co. — Sarasota
Seminole Co. — Sanford
Wakulla Co. — Crawfordville

The Council is also charged with the responsibility of conducting FMA's Recognition Program for Voluntary Health Agencies. On February 15, 1980 a joint meeting was held with representatives of recognized VHA's to discuss mutual concerns and hear reports on the activities of these organizations. In the 1979-80 Association year, fifteen (15) voluntary health agencies were recognized by the FMA:

The Arthritis Foundation, Florida Chapter
American Cancer Society, Florida Division, Inc.
American Diabetes Association, Florida Affiliate
American Heart Association, Florida Affiliate, Inc.
Easter Seal Society of Florida, Inc.
Florida Association for Retarded Citizens, Inc.
Florida Coordinating Council of the National Kidney Foundation
Florida Epilepsy Foundation
Florida Lung Association
Leukemia Society of America, Inc., Florida Division
March of Dimes Birth Defects Foundation
Mental Health Association of Florida, Inc.
National Multiple Sclerosis Society of the State of Florida
National Society to Prevent Blindness, Florida Affiliate
United Cerebral Palsy of Florida, Inc.

All six committees that serve under the Council on Medical Services have been active and the following is a consolidated report of each committee's activities for the year:

The **Committee on Public Health**, chaired by Wilmer J. Coggins, M.D., held two meetings and considered a large number of public health issues. Recommendations were made on such subjects as tuberculosis testing in Florida's prisons; notifying an out-of-state pharmaceutical warehouse that FMA formally objects to the direct mailing advertisements to Florida's teenagers promoting the use and sale of body stimulants; prison drug abuse treatment programs; health care services for dependent children confined in state facilities; maintaining the present county/state relationship for local health departments; and FMA sponsorship of a physician recruitment conference for rural and underserved communities.

Other subjects studied included the state immunization law; triplicate prescription forms; disease reporting; and a considerable amount of proposed legislation.

The **Committee on School Health**, chaired by Don C. Smallwood, M.D., continues to serve as the official State School Health Medical Advisory Committee to the Department of Education and the Health Program Office, Department of Health and Rehabilitative Services.

During the past year, three meetings were held and the Committee made recommendations concerning flagging of student health records for chronic conditions; revisions to the School Health Services Act; updating the School Health Policy Index Manual; and the state immunization law.

Other matters considered included co-sponsorship of a State School Health Conference; drafting a new proposed pre-school physical examination form; the 1979 School Health Services Survey; and vision screening.

The **Committee on Emergency Medical Services**, chaired by Roy M. Baker, M.D., held two formal meetings and had a number of special gatherings to address single issues. Studies were continued on such topics as emergency room cost containment; analyzing FMA's Critical Care Survey for determining the availability of emergency critical care and other highly specialized facilities in Florida; and improving administrative aspects of the State EMS Program.

Presently the Committee is having discussions with representatives of the Department of Health and Rehabilitative Services on the feasibility of the Department contracting with the Florida Medical Foundation for planning and development of state EMS programs and medical directorship of the State EMS Office.

The **Committee on Allied Health Professions**, chaired by Luis M. Perez, M.D., held two meetings during this Association year which included joint sessions with representatives of the following FMA recognized Allied Health Professions:

American Association of Medical Assistants, Florida State Society
Florida Academy of Physician Assistants
Florida Association of Dispensing Opticians
Florida Chapter, American Physical Therapy Association
Florida Dental Association
Florida Dietetic Association
Florida Nurses Association
Florida Occupational Therapy Association
Florida Pharmaceutical Association
Florida Podiatry Association
Florida Society of Medical Technologists
Florida Society of Radiologic Technologists
Florida Society for Respiratory Therapy
Florida Veterinary Medical Association

Recommendations were made on subjects dealing with requiring advanced registered nurse practitioners to demonstrate their proficiency through written examinations within their area of specialty; restricting the number of physician assistants that a single physician may supervise; opposing a drug prescribing role for mid-level practitioners; and acupuncture regulations.

Close attention was given to subjects on rules and regulations for drug sampling; lay midwifery; legislation affecting allied health professions; and special emphasis was given to the monitoring of the new Advanced Registered Nurse Practitioner Advisory Committee to the Board of Nursing, which is responsible for determining what medical acts can be performed by ARNP's and under what form of medical direction.

The **Committee on Sports Medicine**, chaired by Richard B. Shaara, M.D., held two meetings and had several special conferences with representatives from the Department of Education and the Governor's Council on Physical Fitness to discuss the development of an athletic trainer program for Florida. These discussions are continuing and the Committee is hopeful that a program will be established for the creation of athletic trainer positions at all secondary schools within the state.

Other subjects considered by the Committee include non-M.D.'s serving as team physicians; a position statement on athletic injuries; a school athletic physical examination form; analyzing FMA's School Athletic Survey; and communications with county medical societies on sports medicine topics.

The **Committee on Physical Fitness**, chaired by James B. Perry, M.D., was charged with the responsibility for developing programs to promote the Association's 1979-80 theme on physical fitness. Two Committee meetings were held for planning purposes.

A Special Journal Issue on Physical Fitness is scheduled for publication in April 1980. This unique publication contains 32 articles on a broad range of subjects and should be of great assistance to the practicing physician.

There will be a two-day Symposium on Physical Fitness to be held as a Scientific Section during the Annual Meeting Scientific Program. This event will be co-sponsored by the Florida Academy of Family Physicians and will feature both in and out-of-state speakers with national and international reputations in the field of fitness.

During the Annual Meeting, there will also be a two-mile Health Run for physicians, their families and guests. In addition, final preparations are being completed for a six-mile invitational team competition running event, which will include teams representing county medical societies, hospitals, specialty groups, allied health professions, and voluntary health agencies.

RESOLUTION 80-1
Adolescent Drug Abuse
Sarasota County Medical Society

RESOLUTION 80-3
Adolescent Drug Abuse
Pinellas County Medical Society

Due to the similarity of both of these Resolutions, the Reference Committee, along with members of the Association attending the meeting, felt that these two resolutions should be combined and limited to the subject of illegal drug abuse.

The motion of the Reference Committee that Substitute Resolution 80-1 be adopted as amended carried.

SUBSTITUTE RESOLUTION 80-1
Adolescent Drug Abuse

RESOLVED, That the FMA considers marijuana and its derivatives (as well as all other illegal drugs) as harmful substances, especially for juveniles; and be it further

RESOLVED, That the House of Delegates declare its alarm and concern at the increasing use of illegal drugs; and be it further

RESOLVED, That the FMA House of Delegates request the Florida Legislature give strong consideration for legislation to further discourage and penalize the smuggling and sale of illegal drugs and the promotion of such drug usage; and be it further

RESOLVED, That the FMA strongly endorses the concept that the responsibility of the child lies primarily with the parent, and be it further

RESOLVED, That the FMA, through its *Journal* and other resources improve physicians' awareness of this problem and encourage each component county society to disseminate this information to the public through the media and other resources.

The Reference Committee appreciated the concern of the Association as represented by the two Resolutions in the problem of alcohol abuse and would like to submit a Substitute Resolution for 80-3.

The motion of the Reference Committee that Substitute Resolution 80-3 be adopted carried.

SUBSTITUTE RESOLUTION 80-3
Adolescent Alcohol Abuse

RESOLVED, That the FMA express its extreme concern over the statewide problem of the use of alcohol by adolescents; and be it further

RESOLVED, That the law enforcement agencies in Florida be urged to enforce stringently existing laws on the purchase and consumption of alcoholic beverages; and be it further

RESOLVED, That the FMA endorse raising the legal age for purchase and consumption of alcoholic beverages; and be it further

RESOLVED, That the FMA through its component societies support and encourage educational programs for young people on the dangers of alcohol abuse.

RESOLUTION 80-12
Drug Abuse Programs
Hillsborough County Medical Association

The motion of the Reference Committee that Resolution 80-12 be adopted as amended carried.

RESOLUTION 80-12
Drug Abuse Programs

RESOLVED, That the House of Delegates of the Florida Medical Association strongly recommend and urge each component medical society to institute forthwith a program to reduce the abuse of amphetamines and methaqualones, the incidence of stolen and forged prescriptions, and pharmacy burglaries, such program to include:

1. A 48 hour delay in delivery of any amphetamine or methaqualone prescription and that these drugs no longer be stocked routinely in pharmacies.
2. Each prescription be verified by a telephone call to the doctor personally.
3. Physicians reminded to guard carefully their prescription blanks and to take precautions against forgeries and that they not have the narcotic control number (DEA) preprinted on their prescription forms.
4. The assistance and cooperation of local pharmacy association and law enforcement agencies be enlisted. Be it further,

RESOLVED, That the Florida Medical Association request the cooperation of the Florida Osteopathic Association, the Florida Pharmaceutical and the State Board of Pharmacy in this endeavor, and be it further

RESOLVED, That the FMA recommend that the American Medical Association consider this program as a part of a nationwide program.

The Reference Committee expressed its appreciation to all members of the Association who appeared at the meeting to provide guidance and counsel.

Special thanks were conveyed to Dr. Samuel Day who represented the AMA delegates at the meeting. Dr. Campbell expressed his sincere appreciation to members of the Committee for rendering their knowledge and expertise.

The Reference Committee also thanked FMA staff members Mrs. Irene Schmutz and Robert Harvey for their assistance in the preparation of the report.

The Reference Committee expressed thanks to the Speaker and Vice Speaker for their trust and confidence in appointing each of them to the Committee.

The motion that the Report of Reference Committee II be adopted as amended carried.

The Second Meeting of the House of Delegates recessed at 5:30 p.m. to reconvene Sunday morning at 9:00 a.m.

Third House of Delegates

The third meeting of the House of Delegates convened at 9:00 a.m. on Sunday, May 11, 1980, in the Regency Room North of the Diplomat Hotel, Hollywood, Florida, with the Speaker of the House, Dr. Sanford A. Mullen, presiding.

Dr. Franklin H. Pfeiffenberger, Chairman of the Credentials Committee, reported 224 delegates were registered representing 34 county societies, which constituted a quorum, and moved that the delegates be seated. The motion carried.

Delegates

ALACHUA — O. Frank Agee, M.D.; Thomas D. Bartley, M.D.; William B. Deal, M.D.; William T. Hawkins, M.D.; Douglas O. Jenkins, M.D.; Gerold L. Schiebler, M.D.; Diane Zabak — Student Delegate

BAY — Philip Cotton, M.D. (Absent — James D. Nixon, M.D.)

BREVARD — Richard N. Baney, M.D.; Michael J. Foley, M.D.; Brian P. Gibbons, M.D.; Howard W. Pettengill, M.D.; Francis S. Pooser, M.D.; Robert J. Sarnowski, M.D.

BROWARD — Leroy G. Appell, M.D.; Leonard C. Bass, M.D.; Anna M. Blenke, M.D.; Milton P. Caster, M.D.; David A. d'Alessandro, M.D.; Burns A. Dobbins, M.D.; Arthur L. Eberly, M.D.; Kenneth H. Farrell, M.D.; Paul A. Flaten, M.D.; Stanley S. Goodman, M.D.; Theodore W. Hahn, M.D.; William C. Hartley, M.D.; Jerry D. Moore, M.D.; James V. Redd, M.D.; Thomas F. Regan, M.D.; Joseph M. Sachs, M.D.; Peter A. Tomasello, M.D.; Anthony J. Vento, M.D.; Harry B. Weinberg, M.D.; Wilbur F. Helmus, M.D.; David C. Lane, M.D.; George P. Messenger, M.D. (Absent — Robert L. Andreae, M.D.; Donald A. Bolt, M.D.; Robert J. Brennan, M.D.; Phillip A. Caruso, M.D.; Ernest Costantino, M.D.)

CAPITAL — Robert P. Johnson, M.D.; Nelson H. Kraeft, M.D.; Robert N. Webster, M.D.; Jack W. MacDonald, M.D.

CHARLOTTE — Thomas Civitella, M.D.; Charles H. Wingo, M.D.

CITRUS-HERNANDO — W. Randall Jenkins, M.D.; Clinton J. McGrew, M.D.

CLAY — (Absent — Charles T. Dellinger, M.D.)

COLLIER — Nicholas H. Kalvin, M.D.; Virgil A. Ponzoli Jr., M.D.; Joseph F. Sullivan, M.D.

COLUMBIA — Barney E. McRae, M.D.

DADE — Armando F. A. Abadin, M.D.; Edward Annis, M.D.; Jerome Benson, M.D.; Jose S. Bocles, M.D.; Rufus K. Broadaway, M.D.; Luis Cabrera, M.D.; Manuel L. Carbonell, M.D.; Edmund Cava, M.D.; Jack Q. Cleveland, M.D.; Vincent P. Corso, M.D.; O. William Davenport, M.D.; Joseph H. Davis, M.D.; Charles A. Dunn, M.D.; Franklin J. Evans, M.D.; Miguel Figueroa, M.D.; N. Ralph Frankel, M.D.; George R. Gage, M.D.; Joseph Harris, M.D.; Walter Jones, III, M.D.; Robert B. Katims, M.D.; Norman M. Kenyon, M.D.; Melvin A. Klein, M.D.; Norman R. Korman, M.D.; Banning G. Lary, M.D.; Warren Lindau, M.D.; Carlos G. Llanes, M.D.; Simon Markovich, M.D.; Robert Maury, M.D.; Burton T. Meadows, M.D.; Charles A. Monnin, M.D.; Miguel A. Mora, M.D.; Joseph T. Ostroski, M.D.; Jorge R. Pena, M.D.; Pedro A. Ramos, M.D.; Walter M. Sackett, M.D.; Oscar Sandoval, M.D.; Janice K. Sherwood, M.D.; Everett Shocket, M.D.; S. William Simon, M.D.; David Sims, M.D.; Margaret C. S. Skinner, M.D.; Leonard S. Sommer, M.D.; Chauncey M. Stone, M.D.; David J. Talarico, M.D.; Charles F. Tate, M.D.; John C. Turner, M.D.; Thomas B. Turner, M.D.; Edgar W. Webb, M.D.; Harold H. Weiner, M.D.; Sheldon Zane, M.D.; Robert Marema — Student Delegate (Absent — Julian H. Groff, M.D.; Richard D. Miller, M.D.; Moises Mitriani, M.D.; Steven M. Weissberg, M.D.)

DESOTO-HARDEE-GLADES — (Absent — Calvin W. Martin, M.D.)

DUVAL — Mohamed H. Antar, M.D.; James L. Borland, M.D.; James N. Burt, M.D.; Doris N. Carson, M.D.; Yank D. Coble, M.D.; Clyde Collins, M.D.; Patricia C. Cowdery, M.D.; Richard C. Dever, M.D.; Emmet F. Ferguson Jr., M.D.; Walter G. Jarrell, M.D.; John F. Lovejoy Jr., M.D.; Charles B. McIntosh, M.D.; Faris S. Monsour, M.D.; John A. Rush, M.D.; Guy T. Selander, M.D.; Robert H. Threlkel, M.D.; James W. Walker, M.D.; William D. Walklett, M.D.

ESCAMBIA — Robert H. Cohan, M.D.; Eric F. G eiger, M.D.; Charles H. Kahn, M.D.; Robert K. Wilson, M.D.; Henry M. Yonge, M.D.; (Absent — Charles F. McConnell, M.D.)

FLAGLER — John M. Canakaris, M.D.

FRANKLIN-GULF — (Absent — Joseph P. Hendrix, M.D.)

HIGHLANDS — Donald C. Hartwell, M.D. (Absent — Robert T. Rengarts, M.D.)

HILLSBOROUGH — Richard A. Bagby, M.D.; Francis C. Coleman, M.D.; Richard G. Connar, M.D.; Irving M. Essrig, M.D.; John C. Fletcher, M.D.; Thomas H. Greiwe, M.D.; Victor H. Knight, M.D.; Thomas E. McKell, M.D.; John K. Petrakis, M.D.; Michael J. Pickering, M.D.; Ralph E. Rydell, M.D.; Ronald L. Seeley, M.D.; William W. Trice, M.D.; James A. Winslow, M.D. (Absent — Deborah Bradley — Student Delegate)

INDIAN RIVER — Ferdinand F. Becker, M.D. (Absent — Donald L. Ames, M.D.)

LAKE — Frederick C. Andrews, M.D.; Robert Hux, M.D.

LEE — Cecil C. Beehler, M.D.; Larry P. Garrett, M.D.; John S. Hagen, M.D.; Francis L. Howington, M.D.; H. Quillian Jones Jr., M.D.

MADISON — (Absent)

MANATEE — Thomas R. Busard, M.D.; Arthur J. Cohen, M.D.; Julian J. Giraldo, M.D. (Absent — Salvatore J. Cantolino, M.D.)

MARION — C. Brooks Henderson, M.D.; Samuel L. Renfroe, M.D.

MARTIN — Fred S. Carter, M.D.; James A. Gray, M.D.

MONROE — Ronald H. Chase, M.D. (Absent — Robert D. Carraway, M.D.)

NASSAU — (Absent — Jose L. Castillo, M.D.)

OKALOOSA — David R. Arrowsmith, M.D.; Eugene R. Valentine, M.D.

ORANGE — Edward Ackerman, M.D.; Francis M. Coy, M.D.; Clarence M. Gilbert, M.D.; Wm. Edward Hoffmeister, M.D.; Joseph G. Matthews, M.D.; Franklin B. McKechnie, M.D.; Hector R. Mendez, M.D.; Louis C. Murray, M.D.; James F. Richards Jr., M.D.; Thomas G. Sawyer, M.D.; Edward W. Stoner, M.D.; T. Byron Thames, M.D.; Robert B. Trumbo, M.D. (Absent — David L. Mackey, M.D.)

OSCEOLA — George A. Gant, M.D.

PALM BEACH — Vernon B. Astler, M.D.; Richard C. Cavanagh, M.D.; John D. Corbit, M.D.; Gabino S. Cuevas, M.D.; Lee A. Fischer, M.D.; J. Russell Forlaw, M.D.; Luis R. Guerrero, M.D.; James M. Johnson, M.D.; V. A. Marks, M.D.; Benjamin Moore, M.D.; Reginald J. Stambaugh, M.D.; Ben R. Thebaut Jr., M.D.; Dick L. Van Eldik, M.D.

PANHANDLE — Herbert E. Brooks, M.D.; James T. Cook Jr., M.D.
PASCO — (Absent — Robert D. May, M.D.; Morris L. Saperstein, M.D.)
PINELLAS — William W. Atkinson, M.D.; Thomas S. Daniel, M.D. Robert L. Dawson, M.D.; Charles K. Donegan, M.D.; John M. Hamilton, M.D.; Kay Knight Hanley, M.D.; David S. Hubbell, M.D.; Harold L. Ishler Jr., M.D.; Morris J. LeVine, M.D.; Jack A. MaCris, M.D.; Donald G. Nikolaus, M.D.; Rex Orr, M.D.; David T. Overby, M.D.; Frederick O. Smith, M.D.; Walter H. Winchester, M.D.
POLK — Howard M. DuBose, M.D.; John W. Glotfelty, M.D.; Woods A. Howard, M.D.; Thomas E. McMicken, M.D.; James D. Morgan, M.D.; Paul A. Tanner Jr., M.D. (Absent — Saul B. Gerber, M.D.)
PUTNAM — Roy E. Campbell, M.D.
ST. LUCIE-OKEECHOBEE — William H. Meyer Jr., M.D.; Richard Stern, M.D.
SANTA ROSA — (Absent — William N. Watson, M.D.)
SARASOTA — John N. Carlson, M.D.; Samuel E. Kaplan, M.D.; Kenneth C. Keihl, M.D.; Franklin Pfeiffenberger, M.D.; Richard C. Rehmeyer, M.D.; Karl R. Rolls, M.D.
SEMINOLE — Luis M. Perez, M.D.; Frederick J. Weigand, M.D.
SUWANEE-HAMILTON-LAFAYETTE — (Absent)
TAYLOR — (Absent — John H. Parker, M.D.)
VOLUSIA — Charles R. DeArmas, M.D.; William R. Jones, M.D.; Beatrice T. Silverman, M.D.; Alvin E. Smith, M.D.; Charles A. Stump, M.D. (Absent — Frank J. Lill, M.D.)
WALTON — Juan Evangelista, M.D.
WASHINGTON — (Absent — John T. Grace, M.D.)
SPEAKER OF THE HOUSE — Sanford A. Mullen, M.D.
VICE SPEAKER OF THE HOUSE — James B. Perry, M.D.

The Speaker congratulated Dr. Robert B. Katims of Miami on his appointment as Chairman of the Florida State Board of Medical Examiners.

Dr. Mullen explained that the yellow ribbons at the podium and head table were in honor of and tribute to, and to express the concern for the American hostages being held in Iran.

Installation of the President

Dr. Mullen recognized the President, Dr. Richard Hodes, and asked that he come forward to install the new President.

Dr. Hodes asked Dr. Ackerman and Dr. Murray to escort Dr. Thames to the podium. Dr. Hodes presented the personal gavel and President's certificate to Dr. T. Byron Thames, the new President.

Dr. Thames presented Dr. Hodes with the Past President's pin and asked Dr. Coleman and Dr. Seeley to escort Mrs. Marjorie Hodes to the platform, where he presented her with Dr. Hodes' portrait.

Dr. Thames stated that in the past 106 years of its existence, the FMA has embarked on many programs with each of its presidents' special interests, ideas and talents. The offices and members of the FMA have accomplished much of benefit to the health care of Florida citizens through these years and the efforts of organized medicine.



T. Byron Thames, M.D., is escorted to the podium to assume the presidency of the Florida Medical Association. Accompanying Dr. Thames are (left) Louis C. Murray, M.D., Orlando, a Past President of FMA; and Edward Ackerman, M.D., also of Orlando, President of the Orange County Medical Society.

Dr. Thames proposed the scientific theme of the FMA for the year 1980-81 to be Stress and Lifestyle.

Dr. Thames proposed that the FMA review the role of stress in the health process and also review the possible healthier solutions to the problem. He felt that the role and ability of physicians to help their patients cope with stress should be examined. Dr. Thames added that as physicians strive to educate themselves and their patients about stress and a better lifestyle in the year 1980-81, he personally will strive to meet the demands and duties as President of the FMA.

Dr. Thames thanked the Association for their support and endorsement and said he looks forward to the coming year. He introduced his wife, Pat, and his oldest son Randy and his wife, Lynn.

The Speaker resumed the Chair and called for the report of Reference Committee III.



T. Byron Thames, M.D., addresses the House of Delegates for the first time as FMA President.



Incoming FMA President T. Byron Thames, M.D., presents a portrait of retiring President Richard S. Hodes, M.D., to Mrs. Hodes.



In left photo, new FMA President T. Byron Thames, M.D., Orlando, accepts the gavel from outgoing President Richard S. Hodes, M.D., Tampa. In right photo, Dr. Thames attaches Past President's Pin to Dr. Hodes' lapel.



Report of Reference Committee No. III Finance and Administration

Dr. Manuel Carbonell, Chairman, and his committee came forward to present the report of Reference Committee No. III, Finance and Administration.

The Reference Committee had considered the Remarks of the Speaker of the House of Delegates, Dr. Sanford A. Mullen, and commended him for clear and precise rules under which the House of Delegates acts and his summary to us at the beginning of this meeting.

The motion of the Reference Committee that the Remarks of the Speaker be filed as presented carried.

The Reference Committee had considered the President's Address and commended him for his aggressive leadership on behalf of the members of the Association for the past year. The Reference Committee requested the Board of Governors study the possibility of changing the time of the Annual Meeting.

The motion of the Reference Committee that the President's Address be filed as presented carried.

Report A
of the
Board of Governors

The Reference Committee considered Report A of the Board of Governors and commended the Board for its outstanding performance during a very difficult year.

The motion of the Reference Committee that Recommendation No. A-1 be adopted carried.

The motion of the Reference Committee that the Standardized Archives and Application Form be approved in concept and referred back to the Board of Governors for further study by staff, in consultation with county medical societies, to develop a more concise and acceptable form carried.

The motion of the Reference Committee that Recommendation No. A-3 be adopted as presented carried.

The motion of the Reference Committee that Report A of the Board of Governors be adopted as amended carried.

Report A
of the
Board of Governors
Richard S. Hodes, M.D.

Your Chairman is pleased to submit this report to the House of Delegates regarding the activities of your Board of Governors during



Manuel Carbonell, M.D., Miami, was Chairman of Reference Committee No. III (Finance and Administration). Left to right: Walter H. Winchester, M.D., Dunedin; Thomas D. Bartley, M.D., Gainesville; Dr. Carbonell; John N. Carlson, M.D., Sarasota; Brian P. Gibbons, M.D., Cocoa Beach; and Miss Rita Gearhart, Recorder, Jacksonville.

the past year, and also those activities of the Association's Councils and Committees.

Your Board and the many physicians who have given freely of their time in behalf of the Association, have exercised every effort to insure the highest level of medical care for the citizens of Florida and the preservation of the free enterprise system of health care delivery.

This report reflects the high level and broad scope of programs and activities in which the Association is currently involved, both as a result of pursuit of these goals, as well as the many crucial issues which continue to face physicians individually and collectively.

In addition, the report places particular emphasis on the present and future stability of the Association's finances and scope of activities.

Your chairman is grateful for having had the opportunity of serving this fine organization during the past year and it has been a particular pleasure to work with the high caliber of physicians who have served on the Board. Each of them has represented their fellow physicians unselfishly and to the best of their ability:

Vernon B. Astler, M.D.
Richard G. Connar, M.D.
O. William Davenport, M.D.
J. Lee Dockery, M.D.
J. Russell Forlaw, M.D.
Walter C. Jones, III, M.D.
Norman M. Kenyon, M.D.
Thomas E. McKell, M.D.
Sanford A. Mullen, M.D.
Louis C. Murray, M.D.
Eugene G. Peek, Jr., M.D.
T. Byron Thames, M.D.
William W. Thompson, M.D.
James G. White, M.D.
Robert E. Windom, M.D.

To my successor, Dr. Byron Thames, I extend my best wishes for the same rewarding experience that I have enjoyed in serving the FMA and I extend to Dr. Thames my fullest support in facing the crucial issues that affect all physicians.

Major Activities

1980 Annual Meeting — The Board approved the format for the 1980 Annual Meeting with Physical Fitness as its theme. Dr. Henry Yonge was commended for the continuing excellence of the scientific program and noted that physicians would be able to earn up to 20 hours of mandatory CME credit. The Board also commended Dr. Jim Perry, Chairman, and the other members of the Committee on Physical Fitness for their efforts in developing a special Symposium on Physical Fitness to be held in conjunction with the scientific program.

Finance and Management — In my first President's Page in June, 1979, I advised the Association's membership that while the FMA was in a sound financial position with strong and efficient management, it was essential that careful evaluation be made of the scope of activities and expenditures in the face of growing demands upon the Association's resources and an alarmingly inflationary economy.

The Board reviewed the financial report prepared by the Executive Vice President and approved the auditors' statement prepared by the CPA firm, Lucas, Herndon, Hyers and Pennywitt. These reports covered the calendar year 1979 and showed the Association's regular income from all sources of $2,248,084 and total expenditures during the year of $2,044,384 for a net income of $203,699. These figures do not reflect expenditures for equipment or depreciable items as these are a transfer of assets from liquid to fixed. The special assessment for public relations and legislation in 1976 has a balance of $212,895. The total assets of the Association as of December 31, 1979, were $2,835,284 less liabilities of $600,441 for net assets of $2,234,843. The EVP expressed the opinion that if the current level of activities continue with the current rate of inflation in the economy, the Association will probably go into the red in 1980 and that to insure continued fiscal stability, it would be necessary to further reduce activities or increase the dues.

As a result, the Board of Governors authorized the appointment of a Special Sub-Committee on Finances to conduct an independent review and evaluation of the Association's current financial condition and future projections of income and expenditures. The Board approved and transmitted to the House of Delegates the report of this committee which appears on page of this Handbook. In addition, FMA Council and Committee Chairmen were called upon to review and rank, in importance, activities of their respective councils and committees and to make recommendations as to those activities that could be eliminated or which should be added.

Consistent with the careful assessment of future income and operating expenditures, and the appraisal of current and future programs, an indepth review of management has been conducted. Two management studies have been completed utilizing outside consultants who are well respected for their management ability. The favorable aspects and areas where improvement was needed were discussed in detail and appropriate actions taken by the Executive Vice President. Staff has been reduced from 51 to 42 which has resulted in an increased workload and any further reduction could limit the Association's ability to carry out current programs and activities. Those functions of the FMA staff that are not related to a council or committee function have been reviewed for determining those which might be eliminated. Also, there has been a continuing evaluation of the FMA Field Offices to insure the most efficient use of both the staff and office facilities.

The Board has concurred with the desire of the Executive Vice President to phase out of FMA management following the 1984 Annual Meeting. The Board has also concurred in the decisions of the other Boards of Directors who have requested Dr. Parham to continue in his capacity with them, i.e., Attorney-in-Fact/President of the Florida Physicians' Insurance Reciprocal; Chairman of the Board of PIMCO; and President of the Fidelity Life Insurance Company of Florida. The philosophy to be approached regarding the positionof EVP will be considered by the Board in the near future.

The Florida Physicians' Insurance Reciprocal — A consolidated report of finances and other pertinent information on the FPIR for the period December 1, 1975 — December 31, 1979, was mailed to the entire FMA membership with the FMA *"Briefs"* in February. This report reflects the current financial status of the FPIR, levels of coverage, claims activity, investment information and other corporate information. The following is a summary of the highlights of the report:

Board of Directors and Officers

The Board is composed of five subscriber-physician advisors serving on a staggered-term basis. They select their successors or additions subject to approval of the Board of Governors of the Florida Medical Association, Inc. The current members are:

Vernon B. Astler, M.D.
Chairman, Delary Beach, 1986
(Past President, FMA)

Richard S. Hodes, M.D.
Treasurer, Tampa, 1984
(President, FMA)

Jack A. MaCris, M.D.
Vice Chairman, St. Petersburg, 1985
(Past President, FMA)

T. Byron Thames, M.D.
Orlando, 1982
(President Elect, FMA)

O. William Davenport, M.D.
Secretary, Miami, 1983
(Past President, FMA)

W. Harold Parham, D.H.A., EVP of FMA, serves as Attorney-in-Fact and President.

Physician Participation — The Reciprocal has continued to grow, and at the end of 1979 there were over 6,400 physicians insured

out of a potential total market in Florida of approximately 10,000 physicians (Doctors of Medicine). During 1979, the growth rate was approximately 5 percent.

Policy Coverage — The Reciprocal offers three optional levels of liability coverage: $500,000; $1,000,000; and $1,500,000. There is no aggregate, and the form is modified claims-made, participating, with a pre-paid endorsement for death, disability and normal retirement.

Professional Association policies and premiums were discontinued for the 1980 policy year. This will prevent the plaintiff from pyramiding limits and reduce the premium by 20% for those insured physicians in partnership or multi-member professional associations.

Additional $1 Million Layer — The Trust originally offered a $500,000-limit policy, hoping to obtain another half million dollar layer which did not become available until December 1977. The physician now has the choice of coverage as explained above. These extra layers were obtained because of the favorable results and reputation which the Reciprocal has established.

The Reciprocal is the only physician-owned, medical society-sponsored, physician-managed insurance company providing professional liability insurance coverage in Florida and is one of a dozen such plans in America that are able to obtain reinsurance from the London market.

Underwriting — The Reciprocal contracts with the Florida Medical Association, Inc., and its component county medical societies to review and advise regarding physicians meeting underwriting standards of the Reciprocal.

Dividends — After its first year of operation, the Reciprocal declared a dividend equivalent to 7.35 percent of the 1978 premium which amounted to approximately $1.78 million.

During 1979, the Reciprocal declared one dividend to the policyholders of $1 million. There has been a total of 2.77 million dollars returned to the policyholders as dividend since the beginning of the program.

Premiums — For 1980, premiums were reduced by 1.5% for third and fourth-year physicians.

Trends — Since the formation of the Trust in December 1975, the frequency of claims has doubled and the severity of claims has tripled. In addition, the Florida State Supreme Court has declared the mediation panel statute unconstitutional. An increase in premiums will likely occur in 1981 unless these trends moderate and the Florida Medical Association is successful in its support with others for legislation to provide for recovery of defense costs from unsuccessful plaintiffs.

Fidelity Life Insurance Company of Florida — The Reciprocal capitalized and received a permit to organize the Fidelity Life Insurance Company of Florida in December 1979. It has been formed as a desirable profit vehicle for the Reciprocal and also to provide a quality policy with a low load to the policyholders.

The company is still in its formation stages. Reinsurance can be obtained from the American market and the initial capitalization was $1.5 million dollars and several avenues for the expansion of capital are being explored.

FMA Leadership Conference — A record number of 241 officers and others from county medical societies, representing 96% of FMA's membership, took part in the January 26-27 Leadership Conference at the Dutch Inn, Lake Buena Vista. The meeting was for the purpose of providing an up-to-date report on FMA's current and proposed activities and programs.

Your Chairman told those in attendance that the task of getting issues and attitudes out to the membership, along with receiving feedback, is the most difficult job he has faced as President. "The Annual Meeting is not the proper setting for just sitting down and swapping ideas, whereas this meeting is designed as a place where county society officers and executives can receive information about what is going on in FMA."

A broad range of issues were addressed at the Conference, including:

- A summary of the status of FMA Priorities for 1979-80
- The scope of activities of FMA Councils and Committees
- The cost of medical care
- Public relations activities
- A legislative overview and indepth discussion regarding physicians' responsibility in the legislative process, the Auxiliary involvement and political educational activities.
- A summary of Health Regulatory Activities, and litigation and other legal matters affecting the membership.
- A review of the FMA Continuing Medical Education Program
- A look at programs and problems of the large, medium and small size county medical society

A summary of the conference proceedings and presentations were printed in the March issue of the FMA *Journal*.

1979 House of Delegates Referrals

The 1979 Proceedings of the House of Delegates were reviewed and items requiring additional study and action were referred to the appropriate Councils and Committees. Some matters required Board action only. Individual actions regarding the policies of the House of Delegates appear in the various Council and Committee reports as well as in this and other reports of the Board.

Resolution 79-1 — Impaired Physicians — The resolve of this resolution adopted by the House of Delegates charged the Board of Governors with the establishment of an on-going statewide impaired physician program.

Pursuant to the instructions of the House of Delegates in 1979, the Board of Governors approved the President's appointment of an Ad Hoc Committee on Impaired Physicians to study and make recommendations regarding the establishment of an on-going statewide Impaired Physicians Program and to solicit the assistance of the FMA Auxiliary in developing the program.

The Board, pending the identification of the availability of funds by the Executive Committee, approved in principle and referred to the House of Delegates an extensive report and recommendations (included in this Handbook) for the establishment, financing, and implementation of a statewide impaired physicians program for physicians whose use of alcohol or other chemical substances interferes with their ability to practice medicine.



View of the FMA Auxiliary Art Show.

Appointments

The Board of Governors approved the nomination of Richard Connar, M.D., as the AMA Delegate to serve on the Board of Governors. J. Lee Dockery, M.D., was appointed as optional member of the Executive Committee.

Appointed as advisory members of the Board of Governors were Sanford A. Mullen, M.D., Speaker of the House of Delegates; Vernon B. Astler, M.D., Florida Physicians' Insurance Reciprocal; Eugene G. Peek, Jr., M.D., Department of HRS.

Daniel B. Nunn, M.D., was appointed to serve as Editor of *The Journal of the Florida Medical Association* for 1980-81. William M. Straight, M.D., was appointed FMA Historian and Historical Editor of *The Journal*. Norman M. Kenyon, M.D., was designated as the Board of Governors' representative on the Committee on Scientific Publications and Louis C. Murray, M.D., was appointed the Board's representative to FLAMPAC.

Appointed as chairman of standing committees were: Committee on Allied Professions — Luis M. Perez, M.D.; Committee on County Medical Societies — Joseph P. Hendrix, M.D.; FMA Speakers Bureau — Edward Annis, M.D.; Committee on Health Regulatory Activities — Jack A. MaCris, M.D.; Committee on Impaired Physicians — Joseph G. Matthews, M.D.

James T. Cook, Jr., M.D. and Joseph C. Von Thron, M.D., were elected as Chairman and Vice Chairman respectively of Florida's AMA Delegates.

Awards

A. H. Robins Award — The Board reviewed nominations received from county medical societies and selected the recipient of the A. H. Robins Award "For Outstanding Community Service by a Physician." This award will be presented at the First Meeting of the House of Delegates on May 7, 1980. The recipient for this year's award will be included in the Delegates' Packets.

Distinguished Layman Award — The Board has selected the 1980 recipient of the Distinguished Layman Award. The appropriate citation, along with the criteria will be included in the Delegates' Packets.

Nominations

Certificate of Merit — The Board selected an outstanding physician for nomination to the House of Delegates to receive the Certificate of Merit for 1980 (the Association's highest honor of achievement). This nomination will be included in the Delegates' Packets for approval by the House of Delegates.

Certificate of Appreciation — The Board selected a physician to be nominated to the House of Delegates as recipient of the 1980 Certificate of Appreciation. This nomination will be included in the Delegates' Packets for approval by the House of Delegates.

Board Actions of Major Importance

1. FMA Priorities 1980-81 — The Board adopted the following Association Priorities for 1980-81 and directed that Association staff and resources be utilized to carry out these Priorities.

Membership:

Intensify communication with FMA membership directly and through respective county medical and specialty societies.

Public:

Maximize efforts through public relations programs and speakers bureau, press releases, and "truth squad" to provide public with prompt and responsive Association views on:

A. Cost of Medical Care with special emphasis on what organized medicine is doing to stabilize and reduce cost and on the role government plays in escalating costs.

Programs:

A. Physical Fitness with special emphasis on life-style and nutrition.
B. Continued emphasis on local support for legislative activities and development of active political education programs in cooperation with the FMA Auxiliary in each community.
C. Continued implementation of FMA medical services programs with special emphasis on physical fitness, preventive medicine, emergency medical services, and the public health.
D. Continued efforts to establish statewide voluntary Professional Review Organization (PRO) without federal government control and to include private sector (which encompasses Peer Medical Utilization Review).
E. Review by appropriate councils and committees of the scope and necessity of existing and contemplated programs within appropriate recommendations to the Board of Governors.
F. Continue to study the development and marketing of a Medical Encounter Data System for members of the Association.

Association Management:

Insure that Association fiscal status is stable and sound by intensifying efforts to insure that the Association does not over-extend and staff is utilized to achieve program results within budgeted priorities.

Strengthen FMA Branch Office activities to provide assistance to county medical societies in areas of public relations, political education, and key contact physician programs.

Issues:

A. Cost of Medical Care
B. Formation of a coalition to ascertain the effectiveness of the regionalization of the Department of HRS as it pertains to the public's health.
C. Opposition to any compulsory comprehensive national health insurance program.
D. Health regulatory activities involving interference in the practice of medicine.
E. Professional liability

Efforts to intensify communications with the county medical societies, FMA membership and recognized specialty groups has continued during the past year. These efforts are reflected in the Annual Reports of the Committee on County Medical Societies, Council on Legislation, Public Relations Officer, FMA Speakers Bureau and throughout the report of activities of the Board. Activities have included such things as: FMA Field Office liaison with county medical societies and specialty groups; the FMA Leadership Conference; the Association's CMS and Specialty Group Visitation Program; rotation of FMA Board Meetings throughout the state to allow for more participation by medical societies in Board Meetings; FMA recognition of the CMS Executives Conference; meeting of the FMA Committee on County Medical Societies with representatives of county societies; efforts by the Council on Legislation to involve the county societies, Auxiliary and specialty groups more actively in FMA legislative and political educational activities; support of PIMCO Risk Management Seminars throughout the state for professional liability; and sponsorship of a negotiations seminar for physicians serving on

HSA's. In addition, the FMA has endeavored to keep the membership advised of timely issues through the FMA *Journal*, Association Newsletters and by direct contact.

The Annual Reports of the Public Relations Officer and the FMA Speakers Bureau reflect Association activities in addressing issues of public concern and interest in a positive and timely manner. Special emphasis has been placed on the issue of the cost of medical care and the Association has actively participated through physician representatives and staff in the activities of the Florida Committee on the Cost of Medical Care (Voluntary Effort) as well as testifying before state legislative and regulatory bodies regarding matters relating to health care costs. FMA efforts and concerns regarding this issue is further evidenced by the Association's endeavors to work with the Department of HRS to bring about resolutions to problems in Florida's Medicaid Program to make it more cost effective, including a pilot project to provide comprehensive care for Medicaid recipients in Hillsborough County and provision of peer review for Medicaid through the Florida Medical Foundation, FMA's offer to administer the state's EMS and Vocational Rehabilitation Program, and also the Association's offer to provide peer review for Worker's Compensation. These and many other examples of FMA cost containment activities are included in the reports of FMA Councils and Committees included in the Delegates' Handbook.

In the area of programs, a broad range of activities have been carried out throughout the year. Physical fitness and life-style will be the theme for the 1980 Annual Meeting. In conjunction with this theme, there will be a special Symposium on Physical Fitness and also a special program on the Impaired Physician. There will also be a Health Run for all those attending the meeting. The April issue of the FMA *Journal* is devoted to a Special Issue on Physical Fitness and FMA component county medical societies were requested to help promote this theme through sponsorship of local events.

There has been a concentrated effort by the FMA, through its Council on Legislation, to increase county medical society and Auxiliary involvement in legislative and political education activities. Workshops have been held throughout the state for local physicians and their wives. The Board has also enacouraged county medical societies to appoint Auxilians to county legislative committees. This has also been done at the state level and Auxiliary representatives have been appointed in each of Florida's U.S. Congressional Districts to assist Florida's National Key Contact Physicians in carrying out FMA national legislative objectives. The report of the Council on Legislation reflects the positive accomplishments attained in this objective.

Throughout the Board's Report are numerous actions relating to the Association's priority of continued emphasis on medical service programs. The Council on Medical Services and its committees and the Council on Specialty Medicine have devoted countless hours to addressing a wide range of issues relating to all aspects of Public Health. A major effort has been in the area of emergency medical services. Other programs have included: Rural health, school health, sports medicine, drug abuse, physician recruitment, critical care, allied health profession activities, voluntary agencies and many others. FMA Councils and Committees and other representatives have maintained continuing liaison with government bodies as well as representative organizations.

Efforts have continued to establish a statewide voluntary professional review organization (PRO) as a viable alternative to government controlled programs. A vital part of this goal is the current PMUR program conducted through contract with Blue Shield. The PMUR program has been the subject of careful review during the past year for the purpose of improving its effectiveness and equity of operation for all concerned. A report on PMUR is included in another section of the Board Report. The establishment and successful operation of the Florida Health Data Corporation is another vital element in the development of the PRO concept. The importance of participation and cooperation in these activities by Florida physicians is essential to their success. Moreover, the implication of their failure is more and perhaps complete government control of the review procedures of physicians practices which is an integral part of virtually every government health care program.

A major step has been taken in the development and marketing of a Medical Encounter Data System for members of the Association. The Board of Governors at its meeting in October endorsed the "Medical Solution System" for electronic data processing for members of the FMA provided: FMA has appropriate input in the research and development to perfect and keep the software current and practical; an appropriate agreement can be finalized with the owner of the software for the Florida Medical Foundation to receive a royalty income and to monitor the system; and that the FMA expend no funds on this program.

In his first President's Page in the FMA *Journal* in June, 1979, your chairman addressed the need for careful review of FMA activities including the efficient utilization of FMA staff and the composition and scope of functions of councils and committees. Dr. Hodes pointed out that in the face of rapidly rising inflation and the ever-increasing demands on the staff and fiscal resources of the Association, a firm policy determination of future priorities is essential to insuring the future stability of the Association. A comprehensive report and recommendation of FMA finances is included in the Board's report to the House of Delegates.

The Association, through its National Key Contact Physicians and Florida's AMA Delegtes, continue to actively support implementation of the principles embodied in Florida's Resolution 62, adopted by the AMA House of Delegates, regarding National Health Insurance. Opposition to a mandatory, government controlled health care system is a major part of those principles.

The FMA, like many other medical associations, continues to be beseiged by federal and state regulations many of which are detrimental to most basic precepts of quality health care delivery. The Report on Litigation and Investigations included in the Board's Report is harsh evidence of the on-going problem faced by the Association.

Stability in the professional liability insurance market has been a major priority since the PLI crisis in 1975 that resulted in disruption of adequate coverage in the face of a suit-conscious public which severely limited the ability of Florida physicians to practice medicine without exposure to dire financial loss. The professional liability legislative reform package adopted by the Florida Legislature in 1975, along with the establishment of the FMA Self-Insurance Program added stability to the PLI market in Florida. However, since 1976, the number of claims filed and the total cost of settling a claim has risen steadily each year. This situation has been aggravated by the recent decision of the Florida Supreme Court in ruling the mediation panel statute unconstitutional.

A comprehensive report on FMA legislative objectives to help rectify this unfortunate ruling is included in the Board's report to the House.

2. House of Delegates Ratios — In compliance with provisions of the FMA Bylaws to limit as nearly as possible the House of Delegates to a maximum of 250, the Board changed the number of delegates allowed by county medical societies for the 1980 Annual Meeting to one (1) delegate for every fifty (50) active members of the Association within that society and one (1) for any fraction over and above the last complete unit of fifty (50).

3. Memorial to Congress — The Board requested the Florida Legislature to pass a Memorial to Congress in support of the principles encompassed in Resolution #62 adopted by the AMA House of Delegates in December 1978 on National Health Insurance.

4. State Board of Medical Examiners — The Board expressed sincere appreciation to Dr. George Palmer, Executive Director of the SBME for his many contributions and efforts in carrying out the

responsibilities of the Board to protect the general public and in maintaining the integrity and high standards of the medical profession in Florida. The Board noted with pleasure the tribute paid to Dr. Palmer recently by the University of Florida in selecting him as recipient of its Distinguished Alumni Award and also his election as President of the Federation of State Medical Boards of the United States.

The names of physicians previously submitted by county medical societies were reviewed and nominations were submitted to the Governor for consideration for appointment to the State Board of Medical Examiners. The Board is composed of nine physicians and two lay persons.

5. Medico-Legal Code — The Board approved the establishment of a joint liaison committee with the Florida Bar and referred a proposed medico-legal code to this committee for review and recommendations regarding approval of a finalized code by the respective parent organizations.

6. Florida Medical Insurance Trust — The Board authorized a six-month extension of the FMIT program from January 1, 1980 through June 30, 1980.

7. Fuel Crisis — The Board reviewed the adverse effect on health care that could be brought about as a result of the fuel oil shortage in Florida and adopted a policy statement regarding allocation of fuel to physicians, other health professions, and emergency vehicles.

RECOMMENDATION NO. A-1

THAT THE FMA ADOPT THE FOLLOWING POLICY STATEMENT REGARDING A FUEL CRISIS IN THE STATE OF FLORIDA:

"WHEREAS, THERE IS NO STATEWIDE PROGRAM PROVIDED THROUGH THE STATE OF FLORIDA OR THE GOVERNOR'S OFFICE TO GIVE PHYSICIANS PRIORITY FOR GASOLINE IN TIME OF ANY FUEL CRISIS, AND

"WHEREAS, THE FLORIDA MEDICAL ASSOCIATION IS CONTINUING TO ASSIST ITS MEMBERS IN OBTAINING PRIORITY WHENEVER THIS MAY BE POSSIBLE, THEREFORE, LET IT BE

"RESOLVED, THAT THE FMA RECOMMEND THAT EACH COMPONENT COUNTY MEDICAL SOCIETY ACTIVELY PURSUE PRIORITY CLASSIFICATION WITHIN ITS OWN GOVERNMENTAL BODY."

8. Avis Discount Rental Car Program — The Board approved renewal for 1980 of the Avis discount rental car program which will provide a 30% discount to physicians. This is a 5% increase in the discount allowed under the previous program. Additional details will be included in the next FMA *Briefs* to the membership.

9. Vocational Rehabilitation — Florida Medical Foundation was authorized to request the opportunity to submit a bid for administration of the Florida Vocational Rehabilitation program.

10. PIMCO — The Board commended Dr. James W. Walker, President of PIMCO, for the recognition given him in the American Medical News for his outstanding accomplishments in the field of insurance.

11. FMA Auxiliary — The Board commended the Auxiliary for its continued efforts in behalf of the Association and approved the programs of the Auxiliary for 1979-80, the theme which was "Pearls of Wisdom" including: legislation, political education, impaired physicians and continued efforts in the area of child abuse. The Auxiliary has completed a child abuse brochure for distribution to Florida schools, and representatives of the Auxiliary have participated on the FMA's Committee on Impaired Physicians.

12. FMA Medical Defense Fund — The Board continued the Medical Defense Fund established by the Florida Medical Association for the defense of the good name of the medical profession and may be utilized through individual members of the Association willing to assist in defending the good name of the medical profession, provided the individual has the endorsement of his county medical society and is willing to return from the proceeds of any recovery, the amount expended by the Association, said return being allocated to the Medical Defense Funds. In no event shall Medical Defense Funds be utilized to the inurement of individual Association members.

13. FMA Annual Meeting — Blue Shield Informational Meeting — The Board approved a Blue Shield informational meeting to be held in conjunction with the Annual Meeting on Thursday, May 8th, at 8:00 a.m. The purpose of the meeting will be to inform the FMA membership of the current activities of Blue Shield including its proposed future structure.

Health Run — The Board approved FMA spnsorship of a Health Run during the Annual Meeting for physicians, their families and guests. Detailed information will be included in the special Annual Meeting flyer being mailed to the membership.

14. Good Housekeeping's Family Physician of the Year — The Board enthusiastically expressed support for the nomination of Joseph C. Von Thron, M.D., as recipient of Good Housekeeping's 1980 Family Physician of the Year Award.

15. Litigation and Investigations — The Board received a report regarding the status of litigation and investigations the Association has been involved in during the past year.

1. FMA Medical Defense Fund — Sullivan Countersuit Appeal

The Fourth District Court of Appeal, which has had under consideration for some time, the appeal of the Sullivan malicious prosecution suit has over-turned the Judgement in this case. The District Court of Appeal, in a written Opinion, said that Dr. Sullivan had failed to prove the lawfirm of Fee, Parker & Lloyd sued him for malpractice while allegedly knowing the accusation was groundless. The Court's Opinion went on to say that "although some of the facts were in dispute, in ;looking at the evidence with all the conflicts resolved, in Dr. Sullivan's favor and in light most



William B. Deal, M.D., Gainesville (left), Vice President for Health Affairs at the University of Florida, chats with House Speaker Sanford A. Mullen, M.D., Jacksonville.

favorable to him, he had not only failed to prove the lack of probable cause, but, in fact, his evidence establishes probable cause for the filing of the medical malpractice action."

A jury in Ft. Pierce has awarded damages to Dr. Sullivan in a May, 1977 trial. The verdict by the jury awarded Dr. Sullivan $175,000 in damages which was subsequently reduced by the trial Judge to $75,000. This case represents the first time a malicious prosecution suit by a doctor against a lawyer has reached the appellate courts in this State. It will obviously receive a great deal of notoriety and will for a short run, be a set back in the countersuit effort.

2. Feminist Womens Health Center vs. Drs. Mohammad, Crane, Curry, Griner and Messer

Shortly before the Christmas Holidays a request was received from the Capital County Medical Society requesting Florida Medical Association legal and/or financial assistance in the above referenced case. This case had been dismissed on a Motion for Summary Judgement in favor of the defendents two years ago and that Judgement had been reversed by the Fifth Circuit Court of Appeals. Accordingly, the case was remanded to the trial court in Tallahassee and was in fact set for trial during the month of February. The parties were involved in negotiations and that subsequently led to a Stipulation and Joint Motion to Dismiss the Case.

The entire amount of the settlement was paid by the insurance company and was based on an evaluation of the length of the trial proceedings. Under the circumstances that were evident in this case, the Stipulation does appear to protect the medical community in regard to the ethical standards for peer review in the community.

3. FMA vs HEW

This is an action on behalf of the Florida Medical Association and its members, which was filed on March 30, 1978, in the Federal District Court for the Middle District of Florida in Jacksonville. The suit is against the Department of Health, Education and Welfare which sought to permanently enjoin publication of a list which identifies by name every physician in the United States who treated medicare beneficiaries in 1977, and states the amount of income he or she received from the program in that year. The attempt to enjoin the publication of the list is on the basis of violations of the Freedom of Information Act; the Privacy Act; and the right to privacy protected by the First, Fifth, and Ninth Amendments to the Constitution.

Since the initiation of this suit the American Medical Association applied on June 7, 1978, for leave to intervene as a party plaintiff. The District Court granted the application and recertified the class of plaintiffs to include all physicians who practice in the United States and receive income from Medicare. After issuing a series of Temporary Restraining Orders the District Court on July 11, 1978, issued an Ancillary Writ of Injunction restraining HEW from disclosing the list. This unusual Writ of Injunction was warranted, the District Court reasoned, because the parties had submitted all of their evidence on the merits and the Court was not prepared to make the usual preliminary assessment of the merits.

In October 1979, Judge Charles O. Scott granted FMA petition for a permanent injunction which has enjoined HEW from releasing the names of physicians and the amounts they were paid by Medicare during 1977. HEW has initiated an appeal of the decision to the Fifth Circuit Court of Appeals.

4. Unconstitutionality of Medical Mediation Act

In Aldana vs. Holub, the Supreme Court of Florida considered the question of whether the time limitation periods of the Medical Mediation Act, in particular the limitation that requires that a mediation proceeding be completed within ten months of a claim being filed may be extended or stayed in any way and, if not, whether strict application of the Statutory periods is constitutional. In answering the question, the Supreme Court held: (1) the time limitations imposed by the Act are absolute and may not be extended for any reason. If the time limitations are not met, jurisdiction of the mediation panel is lost and mediation terminates. (2) Application of these rigid jurisdictional time limits has proven to be arbitrary and capricious in their application by and in many cases, denying the practitioner his valuable proper right of mediation because the required time limitation could not be met through no fault of either litigating party. (3) Although application of the absolute jurisdictional time period has proven to be intrinsically unfair, the Act cannot be remedied by enlarging the time periods or permitting continuances and extensions of time, for to do so would constitute a denial of a claimants constitutional right of access to the courts. The Court further ruled conclusively, "we are left then with a statute which is intractably and incurably defective and, therefore, hold that Section 769.44 Florida Statutes (79), The Medical Mediation Act, in unconstitutional in its entirety as violative of the due process clauses of the United States and Florida State constitutions." This closes the door on remedial legislation of this nature in the future.

5. FEC vs FMA

Recently the Federal Elections Commission initiated an investigation of a contribution made by the FMA to FLAMPAC. This contribution had been used strictly for administrative and educational purposes and not for contributions to federal candidates, which is prohibited by the Federal Elections Campaign Act. The matter has been responded to and it is anticipated that it will be resolved without any further action by the Federal Elections Commission.

6. U.S. Postal Department Investigation of FMA Special Bulk Third Class Mail Rate

An investigation by the United States Postal Department originating from Washington, D.C. was commenced in May of 1978 with the intent to revoke FMA's Special Bulk Third Class Mail Rate, which it had been operating under for the past twenty years. After an intensive submission of supportive information to the local Postal Authorities, who in turn recommended the continuation of our Third Class Rate, the United States Postal Service issued a ruling on May 17, 1979, with the finding that FMA had submitted a timely written appeal and presented substantial evidence to convince them that FMA's primary purpose still met the criteria for Third Class Bulk Mail Rate.

7. Internal Revenue Service

The Internal Revenue Service has, during the past year, conducted extensive investigations of FMA activities which relate to continuing tax exempt status of a 501C6 organization. During this review special attention was given to legislative activities. This review has now been completed and the Association's tax exempt status has been reaffirmed and continued.

Recently the Internal Revenue Service has again questioned

the activities of the Association in regard to its Pension Trust Fund for employees. This matter is being reviewed and it is anticipated that FMA's position will be justified under the Internal Revenue Code for these type plans.

8. **Workers' Compensation Medical and Surgical Fee Schedule Petition**

Pursuant to instruction by the House of Delegates, a Petition was filed requesting an amendment to the Medical and Surgical Fee Schedule under the Florida Workers' Compensation Act. A hearing was held in Tallahassee on our Petition on December 10, 1979. The Petition called for an across-the-board thirty-five percent increase in the Medical Surgical Fee Schedule and the designation of a three level office visit code. The Department approved the Petition and has adopted a rule implementing the thirty-five percent increase which will be effective July 1, 1980.

9. **Arthur Cohen, M.D. vs. Florida Medical Association**

In 1978 the Association received a letter from Stanley M. Rosenblatt writing on behalf of his client, Arthur Cohen, M.D., a member of the FMA. The letter sought to clarify certain information regarding the "financial support to Doctors who counter-sue lawyers and their clients who bring what the Association believed to be unjustified malpractice suits". (FMA Defense Fund) Subsequently, FMA received Service of Process of a complaint for Declaratory and Injunctive Relief that was filed by Mr. Rosenblatt on behalf of Dr. Cohen seeking to prevent FMA from pursuing illegal purposes that were contrary to its Bylaws and Charters, i.e., specifically involving making contributions to members who were involved in "countersuits". Various Motions were initially filed that removed this case from Broward County to Duval County. On June 25, 1979, pursuant to an FMA Motion to Dismiss, the Circuit Judge granted a Motion to dismiss the complaint with prejudice. An appeal of this decision was not sought by Dr. Cohen and the case has thus been closed.

10. **Davidson, Coria vs. FMA, PIMCO, FPIR**

This is an action by two Key West physicians alleging that they were improperly terminated by the Florida Physician's Insurance Reciprocal. The Florida Medical Association and PIMCO have been joined in this matter by the plaintiff's on the theory that there is an alleged conspiracy among the organizations that resulted in the termination of insurance coverage for these physicians. This matter went to trial in April of 1979 and a mis-trial was granted on the basis of a statement made by the plaintiff attorney in his opening statement to the jury. The case has now been scheduled for trial commencing on May 23, 1980.

11. **Justice Department Anti-Trust Investigation**

In January of 1978, the Florida Medical Association received a Civil Investigation Supeona from the Anti-Trust Division of the United States Department of Justice. These investigations requested discovery of files and information relative to conduct perceived by the Anti-Trust Division to be a restraint of trade in the provision of medical services of members of this Association. The thrust of this investigation was directed toward the FMA Ethical Criteria for Hospital Based Physician Contracts, which has since been rescinded by the House of Delegates. A new Policy Statement on this subject was enacted by the House in May of 1979. There has been further communication and follow-up with the Justice Department and a formal request made to the Department to terminate this matter in view of the actions taken by the House of Delegates.

12. **FEC Conciliatory Agreement** — On February 5, 1980 the Florida Medical Association entered into a Conciliation Agreement with the Federal Elections Commission that terminated an investigation that had commenced in October of 1976. The Conciliation Agreement provides that if the combined total contribution given between FLAMPAC and AMPAC exceed the legal contribution limitations for federal candidates, then the last to contribute to that particular candidate would be responsible for withdrawing their contribution that put the amount over the limit. The Conciliation Agreement recognized that no laws had been violated and therefore there were no penalties assessed against FLAMPAC under the Federal Elections Campaign Act. Identical agreements were signed with the Federal Elections Commission by AMPAC and numerous other State Political Action Commitees.

13. **Department of Professional Regulations** — During the 1979 session of the Florida Legislature a law was enacted that requires the Department of Professional Regulation to require licensees and licensed establishments under their jurisdiction, to post a sign in a conspicuous place that notifies individuals of a number they may call if they have a complaint. The Board of Governors of the Florida Medical Association has authorized legal action to be taken to seek a declaratory judgement and injunctive relief against the Department in carrying out this particular provision. At the present time the Department has not moved to implement statute insofar as physicians are concerned. We are standing by prepared to initiate our action at the appropriate time. The thrust of our lawsuit will be concerning the applicability of the statute to physician licensees and the constitutionality of the provision.

FMA Councils and Committees

The single greatest asset of the FMA is its members and their individual and collective efforts to insure a viable and effective Association influence in all facets of health care delivery.

Almost 200 physicians have served on Association councils and committees during the past year. Others have represented the Association in meetings and activities at all levels.

These dedicated physicians are far too numerable to pay individual recognition to in this report, but your chairman wishes to thank each and every one for the countless hours devoted to the many programs and activities in which the Association is involved for the betterment of the public health, and in the best interest of all the physicians of Florida.

The Board's actions regarding the reports and recommendations of councils and committees during the past Association year are summarized in the following pages and in the other reports of the Board. The Annual report of their individual activities is included in this Handbook.

Committee on County Medical Societies

Standardized Membership Applications — At the 1979 Annual Meeting of the House of Delegates, the Board reported to the House that the Board had approved in principle a standardized membership application form that could be used for membership in the county medical society and FMA, and that FMA make these forms available to county medical societies upon request and further to advise county medical societies that the Board recommended that the Standardized Form be finalized for presentation at the 1980 Session of the House of Delegates.

This proposal originated from a county medical society and was initially considered by the Committee on County Medical Societies.

The Committee conducted a survey of county medical societies regarding the membership applications currently in use. After a review of the applications received, a proposed composite application and Data for Archives form was prepared. This form includes all information required by the FMA Archives Form and has been expanded to include whatever additional information could be anticipated to be requested by county medical societies. The application was designed so that the first part (FMA Data for Archives Form) could be prepared in triplicate and supplied to county societies with one completed copy returned to the FMA. In January of the year, the form was sent to county medical societies for review and comment.

RECOMMENDATION NO. A-2

THAT A STANDARDIZED FMA DATA FOR ARCHIVES FORM AND COUNTY MEDICAL SOCIETY MEMBERSHIP APPLICATION BE ADOPTED AND THAT THE FMA OFFER TO MAKE THESE AVAILABLE TO LOCAL COUNTY MEDICAL SOCIETIES.

Florida Physicians Association — The Board referred to the Florida Physicians Association the recommendation that a careful evaluation be made of the purposes and activities of the Florida Physicians Association and its appropriate role in representing physicians in dealing with third parties in the face of increasing activities by independent organizations such as the Florida Physicians and Dentists Union which is a recognized collective bargaining agent for its members.

Cost of Medical Care — The Board referred to the Judicial Council, the observation of the Committee on County Medical Societies that there is a need for the FMA to provide guidance to county societies in dealing with the issue of the cost of medical care, specifically as to how to most effectively deal with the physician who consistently overcharges.

PLI/CME — The Board referred to the Florida Physicians' Insurance Reciprocal the recommendation that consideration be given to including the total number of continuing medical education hours completed on the Annual Application for Renewal of Professional Liability Insurance coverage under the Florida Physicians' Insurance Reciprocal and that this be a factor considered in approval or disapproval of coverage.

CMS Executives Conference — The Board approved recognition of the County Medical Society Executives Conference and encouraged continued efforts to strengthen staff ties between FMA and component county medical societies.

FMA Speaker's Bureau — The Board received a report on the activities of the FMA Speaker's Bureau during the past year and expressed appreciation to Dr. Ed Annis, Chairman, for his efforts in behalf of FMA. The Board acknowledged that FMA's activity in the areas of nutrition and physical fitness offers an excellent opportunity to speak out on cost containment and other important issues that the public and physicians are faced with today and re-emphasized that public relations begins with the doctor and his patient.

FMA Councils and Committees

COUNCIL ON SPECIALTY MEDICINE

HRS Mental Health Office Director — The Board reaffirmed the previous position of the FMA that while the FMA supports the appointment of physicians to positions of authority in government programs relating to health care, the FMA will not interfere with the government's hiring policy unless requested to do so.

RECOMMENDATION NO. A-3

THE BOARD RECOMMENDS ADOPTION OF THE FOLLOWING AMENDMENT TO THE FMA BYLAWS:

Chapter II, Meetings — Section 1, Annual Meeting — Amend Item 5 as follows:

> 5. Persons Prohibited — No person who is under sentence of suspension or expulsion from any component society of the Association, or whose name has been dropped from its role of members, shall be entitled to any of the rights or benefits of the Association, or be permitted to take part in any of its proceedings until such time as he has been relieved of such disability, and/or no member of the Association who has instituted litigation against the Association shall be permitted to attend any session of the House of Delegates or any other meeting of the Executive Committee, Executive Board or any other committee or section meeting relating to that case.

(This amendment adds the language underlined)

Chapter VII, Board of Governors — Section 1, Composition — Amend third paragraph as follows:

> The Board at its discretion may select to serve on the Board of Governors in an advisory capacity, for a term of one year each, a representative from the Florida Department of Health and Rehabilitative Services, from the State Board of Medical Examiners, ~~from the Board of Directors of Blue Shield of Florida, Inc.~~, from the . . . all of whom must be members of the Association.

(This amendment deletes the language stricken)

Chapter X, Income and Expenditures — Section 2, Dues — Amend Item 1 as follows:

> 1. Annual Dues — Annual dues shall be assessed, as hereinafter provided, by the House of Delegates and shall currently be $175.00 per year ($50.00 of which is to be earmarked for public relations and legislative educational activities) for active members, $50.00 per year for associate members, $10.00 for medical interns and full time physicians in an approved residency or internship, and $10.00 per year for student members. ~~Included in all dues is an annual subscription to *The Journal of the Florida Medical Association* and one copy annually of the current *Florida Medical Directory*.~~ Payment of dues for all classes of membership shall include a subscription to *The Journal of the Florida Medical Association* and one copy of the *Florida Medical Directory* for the current year; and shall include an amount for a pre-paid lifetime subscription for the above publications in the event the physician remains a member and is excused from payment of dues for any reason.

(This amendment deletes language which is stricken and adds language underlined)

Chapter XI, Component Societies — Section 3, Membership — Amend Item 1, Qualifications and Requirements as follows:

. . . Since membership in a component society is a prerequisite to membership in the Florida Medical Association ~~and the American Medical Association~~ . . .

(This amendment deletes the language stricken)

Report F
Board of Governors

The motion of the Reference Committee that Report F of the Board of Governors be adopted as presented carried.

Report F
Board of Governors
Richard S. Hodes, M.D., Chairman

The following supplemental report of the Board of Governors has been prepared summarizing actions which were not included in the Board's report in the Delegates' Handbook.

Judicial Council

In compliance with the FMA Bylaws, the Board of Governors has considered nominations for terms expiring on the Judicial Council in 1980. The Board nominates O. Frank Agee, M.D., to the House of Delegates for election to the Judicial Council as the representative from District A for a five-year term.

Committee on Membership and Discipline

In compliance with the Bylaws, the Board has reviewed terms expiring in 1980 on the Committee on Membership and Discipline. Nominations from county medical societies have been considered, and the Board nominates the following physicians for election to the Committee on Membership and Discipline for the terms indicated.

District 1	Robert Palmer, M.D. (84)
District 2	James T. Cook, Jr., M.D. (84)
District 3	John A. Rush, M.D. (84)
District 4	Richard W. Snodgrass, M.D. (84)
District 5	Frederick C. Andrews, M.D. (84)
District 6	John T. Karaphillis, M.D. (84)
District 7	William B. Hopkins, M.D. (84)
District 8	Wiley E. Koon, M.D. (84)
District 9	Clarence M. Gilbert, M.D. (84)
District 10	Douglas R. Murphy, M.D. (84)
District 11	Ray E. Murphy, M.D. (84)
District 12	Anthony J. Vento, M.D. (84)
	John I. Williams, M.D. (83)
District 13	Arthur W. Wood, Jr., M.D. (84)
District 14	Rufus K. Broadaway, M.D. (84)
District 15	Norman M. Kenyon, M.D. (84)

Report of
Public Relations Officer

The Reference Committee commended the Public Relations Officer and the continual improvement of the Public Relations Program.

The motion of the Reference Committee that report of the Public Relations Officer be adopted as presented carried.

Public Relations
Vernon B. Astler, M.D., Public Relations Officer

Modern society still has tremendous respect for the physician. But, it has adopted new standards on the demands it makes of the private practitioner, both as an individual, and collectively as a profession. No longer can a physician remain aloof from community affairs and hope that talent as a healer will offer protection from public criticism.

That is why FMA's public relations program has placed heavy emphasis during 1979-80 on "responsiveness" and "communications." As a society and as individuals we must deal with the elements of our society and environment as "leaders" entering a new decade. The only other choice is to be led.

During the past year an instant response network has been implemented for the purpose of improving and enhancing the Association's response to major articles or commentaries in the news media which reflect in a positive or negative manner on medicine in the state. With the assistance of the FMA field offices, news media sources throughout the state are continually monitored and we are, in most cases, able to respond to statewide media output in 24 hours or less.

However, it was recognized that entree to the news columns was not enough. Editorial policy is made at the top management level. In order for physician spokesmen to be solicited for comment before editorials are written, there must be an established rapport and continuing dialogue. To achieve this, the leadership of FMA visited with the publishers and editorial boards of the nine major circulation daily newspapers in the state. During these visits, some misunderstandings which had previously inhibited a cooperative relationship, were cleared up between the county medical society and the local paper. In all cases foundations for open communications between editors and physicians were established.

At the same time, the program of solid "basics" launched in 1976 has been continued and enhanced. Newspapers throughout Florida utilize FMA's *"Medical Message"* columns and acceptance of the high school newspaper *"Teenage Medical Message"* columns has been outstanding. One column, on marijuana, has exceeded all others combined in generating interest. Two thousand reprints have been distributed to high schools asking for copies for individual distribution and even more are being requested.

FMA is continuing the popular five minute public service radio programs. One series was done this year using the annual theme of Physical Fitness/Lifestyle and another will begin airing in early summer with a number of programs developed from the theme of Stress. New innovations for gaining more public service time on radio are under study.

A new half-hour television film is in progress to supplement the continuing popularity and use of the two earlier film efforts, *"It's Your Life"* and *"It's a Matter of Life."* The major theme of the film will be emergency medical service capability in the state and includes a subtheme pointing out cases that should be seen by a regular physician rather than in the emergency room.

FMA's reliability as a resource for medical information by the media also demonstrates the effectiveness and credibility of the public relations program. Members of the media from all over the state call several times a week for comments or to substantiate information. This gives the Association a vital open line of communication.

Our public relations program is also being recognized for its excellence by other state societies and AMA. This year numerous requests from other state public relations departments for details on how FMA has accomplished its goals have been answered. Two states are now planning editorial tours patterned after the successful Florida project.



Past Presidents of the FMA Auxiliary were recognized at the Annual Awards Luncheon. Among those present were (left to right): Mrs. C. Brooks Henderson (1975-76); Mrs. Willard L. Fitzgerald (1964-65); Mrs. Perry D. Melvin (1957-58); Mrs. John M. Butcher (1960-61); Mrs. W. Dean Steward (1961-62); and Mrs. Wesley S. Nock (1971-72).



Mrs. B. David Epstein presented the President's Gavel to incoming President Mrs. Fred. P. Swing (right).

Auxiliary Highlights



Former President Mrs. Thomas B. Thames presented Mrs. B. David Epstein with the Past Presidents Pin.



Mrs. John W. Chidsey Jr., accepts an AMA-ERF Certificate of Appreciation for the Orange County Auxiliary from Mrs. LaVere G. White.



Former Editor of *The FMA Journal,* Gerold L. Schiebler, M.D., and Mrs. Paul H. Sherman.



Mrs. John F. Vaughan, President-Elect of the AMA Auxiliary (at podium) installed the new officers of the FMA Auxiliary. From right to left: Mrs. Fred P. Swing, President; Mrs. Frank C. Coleman, President-Elect; Mrs. Michael J. Foley, First Vice President; Mrs. Jack W. MacDonald, N.W. District VP; Mrs. Guy T. Selander, N.E. District VP; Mrs. Charles Stump, E.C. District VP; Mrs. Michael J. Murray, S.W. District VP; Mrs. Rex Orr, W.C. District VP; Mrs. N. Harry Carpenter, S. District VP; Mrs. Daniel B. Nunn, Treasurer; and Mrs. Milton Tignor Jr., Recording Secretary.

Two special programs received outstanding media coverage during the year. FMA's participation in the jail health care project with AMA and the Federal Law Enforcement Assistance Agency was launched with a press conference in Tallahassee. It became the news story of the hour on radio and received prominent play around the state in newspapers. During December a radio public service announcement on the Volunary Effort, featuring popular Miami Dolphin Coach Don Shula, was also released with excellent acceptance.

The Association will also present awards to winners in the third annual Excellence in Medical Journalism Contest during the Annual Meeting. Categories include radio, newspaper, magazine, and television. Media response to this public relations program has grown each year.

In keeping with the Association's priorities during the past year in the area of internal public relations, efforts have been made to intensify communication with the FMA membership directly through county medical societies and specialty groups. Summaries of all FMA Board meetings have been printed in the FMA *Journal* and timely information regarding FMA activities and programs have been transmitted to the membership through the Association's newsletters.

The FMA Leadership Conference was another format for conveying timely information on issues and major programs.

In addition, special emphasis was placed on the Association's visitation program with component county societies and specialty groups utilizing officers, members of the Board of Governors, and appropriate staff. This program, which has been extremely well received, was intended to bring the FMA closer to its membership and also to enhance liaison and cooperation with FMA-recognized specialty groups.

The FMA Speakers' Bureau has continued as an important and effective PR tool. A report to the House of Delegates on the activities of the Speakers' Bureau during the past year is included in the Delegates' Handbook.

A number of other projects are under study and consideration to meet the trends in presenting an accurate picture of organized medicine and, in particular, the role of the private physician during the 80's. The success of these efforts and that of FMA itself will depend to a large part on the continued efforts of the membership at the local level. They are the most important element of the public relations program.

The on-going cooperation of the entire FMA membership is earnestly solicited in the most important public relations effort that we can obtain — a warm and understanding doctor-patient relationship.

Report of Special Committee of the Board on Finance

The Reference Committee heard extensive testimony regarding the Special Committee of the Board on Finance. One observation which holds some merit in the opinion of the Reference Committee is that the increase of dues in the Association should be more frequent and, if necessary, smaller in amount rather than infrequent, larger increases.

The Reference Committee commended the Board of Governors and Special Committee for their foresight in conducting a study and presenting recommendations before a financial crisis occurs. A thorough and in-depth study of the Committee's report was conducted, including a review of the CPA audit for the fiscal year 1979 for the Association. The CPA fiscal audits for 1979 by Lucas, Herndon, Hyers and Pennywitt were also made available to the Reference Committee and those physicians in attendance for the Florida Medical Foundation, FLAMEDCO, FLAMPAC, PIMCO and the Florida Physicians' Insurance Reciprocal.

The motion of the Reference Committee that the Special Committee of the Board on Finance be congratulated and that the House of Delegates strongly support the adoption of the report and recommendations as presented carried.

Special Committee of the Board on Finance

Jere W. Annis, M.D., Chairman
T. Byron Thames, M.D.
J. Russell Forlaw, M.D.

INTRODUCTION

President Hodes, through his President's Page in June 1979, advised the Association's membership of the need for careful evaluation of the scope of its activities and expenditures and the necessity for restraint in the face of growing demands upon its resources in an alarmingly inflationary economy. He further advised the county medical society officers at the FMA Leadership Conference in January 1980 that in making his presidential appointments he had endeavored to streamline and consolidate activities wherever possible without sacrificing effectiveness or imposing undue hardship on those physicians who give so freely of their time in behalf of the FMA. He further advised the Conference that the Association was currently in a sound financial position with alert, strong and efficient management.

The Board of Governors at its meeting in January 1980 authorized the appointment of a Special Subcommittee of the Board on Finance to conduct an indepth review and evaluation of the Association's current financial condition, as well as its future projection. This Committee was to report back to the Board at its March 15th meeting, it being anticipated that a special report would be presented by the Board to the House of Delegates for its consideration in May.

OBSERVATIONS AND REPORT

The Committee met on two occasions and carefully reviewed detailed financial statements and specific data requested from and submitted by the Administration. After a careful evaluation of this data, and of the Association's overall financial status for the past ten years, and after establishing projections for the next five years, the Committee submits the following report and recommendations.

OBSERVATIONS

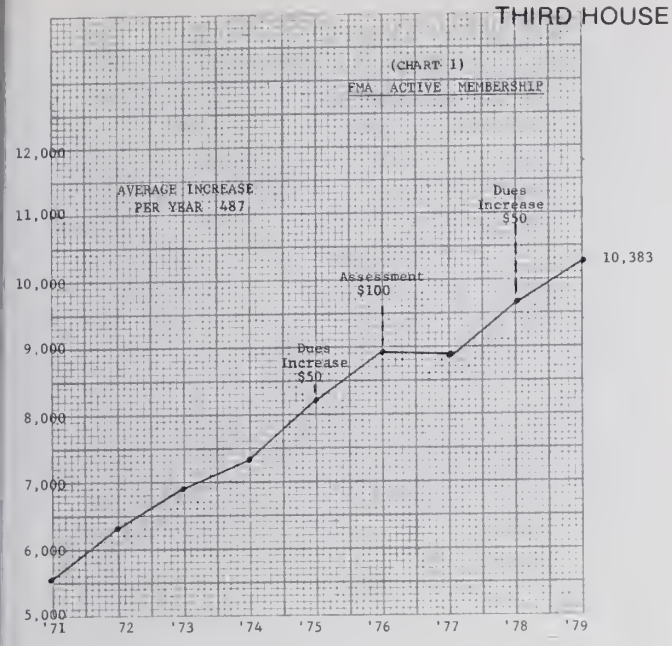
A. The Past Ten Years

The past decade reflects:

1. Sound financial planning and management which has steadily increased the assets of the Association to meet an ever increasing budget and inflation.

Net Worth, 1969:	$ 649,819
Net Worth, 1979:	$2,234,843

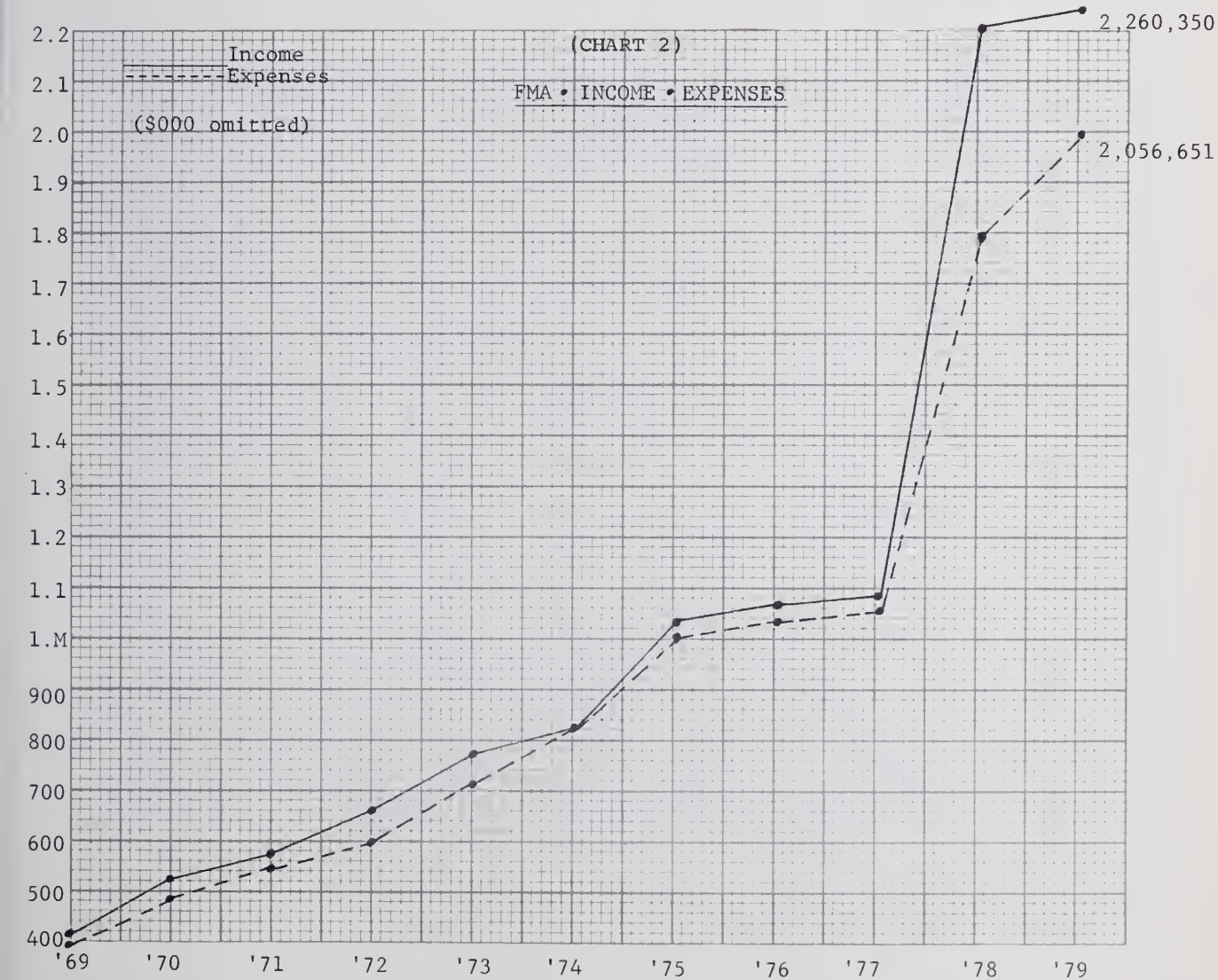
2. The achievement of an outstanding unrelated business and investment income that has far exceeded that of any average Association.
3. A history of dues increases of $50 in 1975 and again in 1978, and a special $100 assessment in 1976.

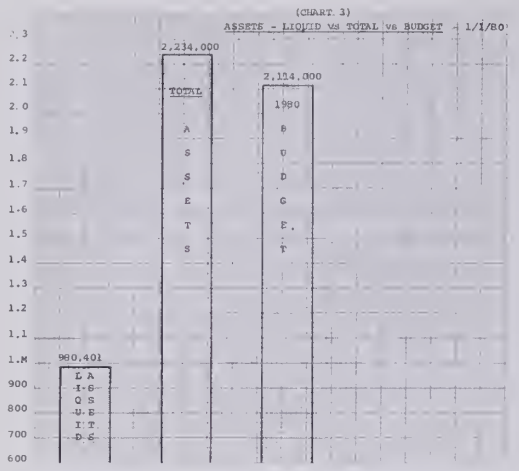


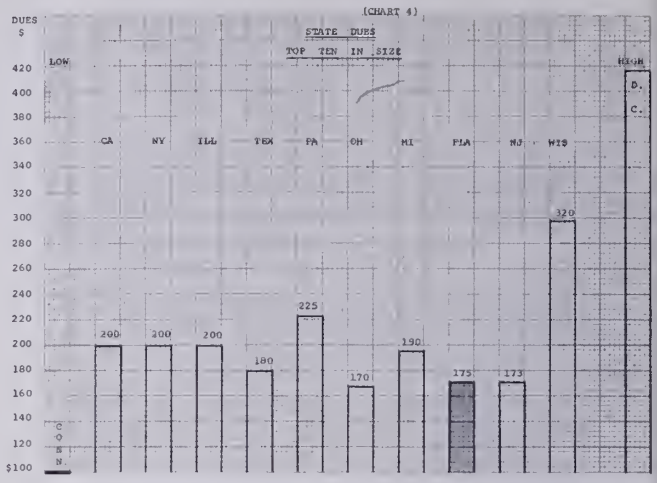
4. Superior fiscal management and direction by the FMA leadership and staff.
5. A growth in active membership from approximately 4,600 in 1969 to 10,383 in 1979, an average of 487 physicians, or 8.8% annually. It is interesting that this has been virtually unrelated to dues increases. (Chart I)
6. Increased income of from $400,603 in 1969 to $2,260,350 in 1979. This represents $188,000 or 60% annually. (Chart 2)
7. An increase in expenses from $397,423 in 1969 to $2,056,651 in 1979. An increase of $177,000 or 62% per year. (Chart 2)
8. Increasing government intervention in the practice of medicine and specifically in the affairs of the Association. This, together with resulting litigation, has had a devastating effect on the Association's cost of operation. It would seem likely that this unfortunate situation will continue.

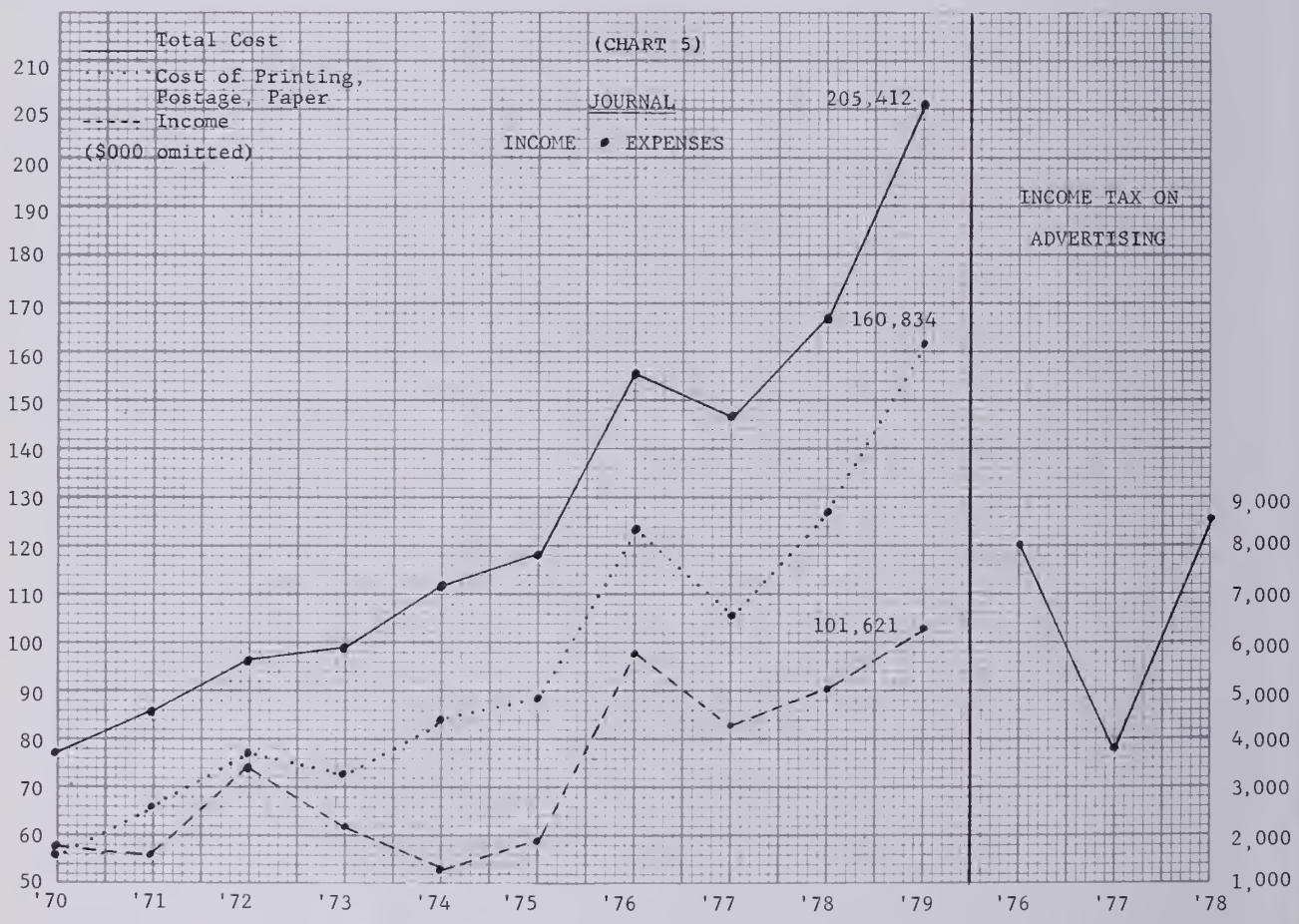
B. The Present

1. Last year's assets ($2,234,843); expenditures ($2,056,651).
2. Liquid assets ($980,401) are approximately 44% of the Association's total assets ($2,234,843) and represent 46% of the 1980 budget ($2,114,000). We believe that the Association's liquid




(CHART 3)
ASSETS - LIQUID vs TOTAL vs BUDGET - 1/1/80
2,234,000
TOTAL ASSETS
2,114,000
1980 BUDGET
980,401
LIABILITIES


(CHART 4)
STATE DUES
TOP TEN IN SIZE
DUES $
LOW
HIGH
D.C.
CA NY ILL TEX PA OH MI FLA NJ WIS
200 200 200 180 225 170 190 175 173 320
COST $


(CHART 5)
Total Cost
Cost of Printing, Postage, Paper
Income
($000 omitted)
JOURNAL
INCOME • EXPENSES
205,412
160,834
101,621
INCOME TAX ON ADVERTISING
'70 '71 '72 '73 '74 '75 '76 '77 '78 '79 '76 '77 '78

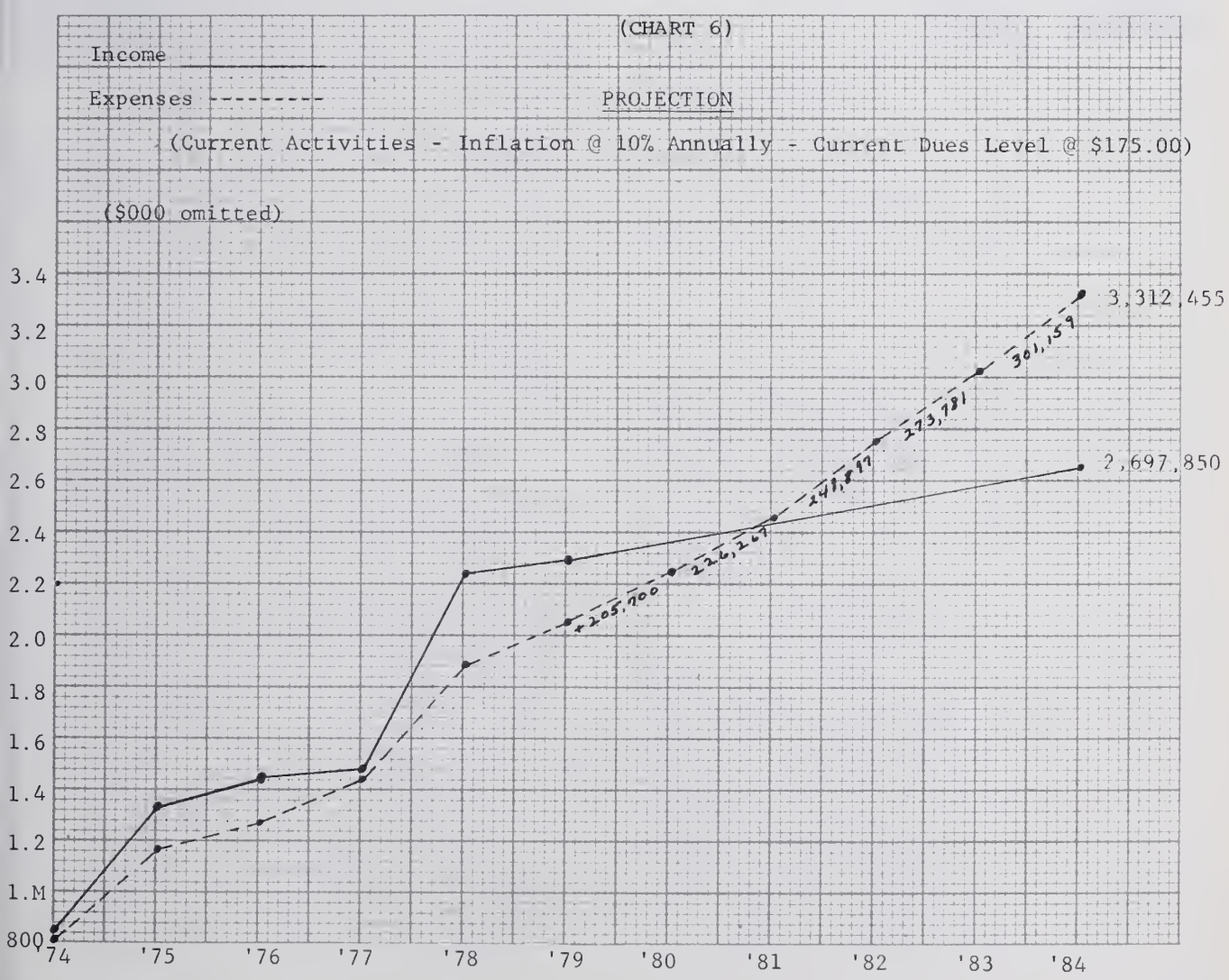
assets should be kept at approximately 50% of the annual operating budget. (Chart 3)

3. This year the Association should just operate within its budget unless there are emergency unbudgeted items due to government intervention, lawsuits or other crises.
4. FMA membership dues rank eighth among those of the ten largest state medical associations in the United States. The range is from $320 to $170 annually. (Chart 4)
5. The median state medical association dues in the United States are $200 a year and at $175, the FMA ranks 36 nationally. The median dues for the south Atlantic states are $175.
6. The FMA Council and Committee membership has been significantly reduced by your President during the past year without loss in efficiency of operation.
7. The FMA staff has been reduced from 50 to 42 during the past year, without loss of service to the members. These reductions however, have, in our opinion, reached a point at which they cannot be further enhanced without bringing about decreased productivity and effectiveness. Indeed some of the reductions must be regarded as being temporary in nature if we are to maintain all of our current programs.
8. In January 1980 the FMA sold its headquarters building in Jacksonville for a profit of $600,000. This was on a cash investment of $300,000 made three years prior. The Association is now in the process of relocating to a nearby, less expensive and more efficient building.
9. The capital office in Tallahassee is owned by the Association and appears to be an excellent investment.
10. In the past, the largest expenditures of the Association have been in the following areas: personnel, general association activities, the Journal, legislative programs, public relations. (Chart 5)

C. Projections for the next five years.

1. The anticipated growth in active members by January 1985 is approximately 2,500 or just under 500 per year. This would provide a total active membership of approximately 14,200 at that time.
2. The anticipated dues income as a result of such growth at the current dues rate would be an increase of $87,500 annually, or a total dues income from active members of $2,485,000 in 1984.
3. Total annual expenses and operating costs based upon the current level of activity and with an anticipated inflation rate of 10% annually, will rise to $3,312,455 by an increment of $1,255,804. (Chart 6)

It is apparent that deficit financing is inevitable if the current level of activity is maintained, if government intervention continues, and if







New FMA President and Mrs. T. Byron Thames, M.D., of Orlando (left picture). At right, the new President-Elect, Sanford A. Mullen, M.D., Jacksonville, and Mrs. Mullen.

inflation follows our projection, unless some additional sources of income are obtained. (This would probably be in the form of dues increases.) This deficit financing which the Florida Medical Association has conscientiously avoided in past years can be expected to begin next year unless drastic steps are taken.

RECOMMENDATIONS

Your Committee recommends:

1. That the House of Delegates authorize the Board of Governors to rigidly limit and curtail the scope of activities of the Association, its councils and committees within the organization's stated objectives in order to insure fiscal integrity through 1980 and 1981. Special emphasis should be given to those activities which directly affect the membership of the Association.
2. That the Board of Governors implement such a reorganization plan as is necessary to accomplish this objective and report back to the House of Delegates in 1981 with definite recommendations regarding the financing of the Association for future years.
3. That the Executive Committee (through the Board of Governors) annually present to the House of Delegates not only a complete report of the financial status of the Association but a recommendation regarding the amount of dues necessary for the upcoming year in order to maintain the Association's financial stability and integrity.
4. That the House of Delegates authorize the Board to establish a special Trust Fund for the current and future reserves of the Association, the initial funding coming from the approximately $600,000 profit for the sale of the headquarters building in Jacksonville. The trustees of this fund might be the last five living past-presidents and perhaps consideration should be given to the addition of one or two lay financial advisors. The trustees would release income and other funds to the Association only when it became absolutely necessary for a matter of great importance to the Florida Medical Association and upon request of the Board of Governors. The use of such funds should be contemplated only when an emergency existed that could not be financed through the regular income and assets of the Association.

Committee on AMA Delegates

The motion of the Reference Committee that the Report of the AMA Delegates be adopted as presented carried.

AMA Delegates

James T. Cook Jr., M.D., Chairman

It has been my pleasure to once again serve as Chairman of the AMA Delegates during the past year and I greatly appreciate the assistance of the Vice Chairman, Joseph C. Von Thron, M.D., Cocoa Beach. I wish to thank all our delegates who have given of their time and efforts in support of the best interests of Florida's physicians in the AMA's House of Delegates: Rufus K. Broadaway, M.D.; Richard G. Connar, M.D.; Samuel M. Day, M.D.; Charles K. Donegan, M.D.; Joseph C. Von Thron, M.D. I would like to pay special thanks to our alternate delegates for their interest and full attendance at all meetings and for their assistance at Reference Committees and at Sessions of the House of Delegates: Vincent P. Corso, M.D.; Eugene G. Peek Jr., M.D.; T. Byron Thames, M.D.; William J. Dean, M.D.; Francis C. Coleman, M.D.; Jack Q. Cleveland, M.D.; and Vernon B. Astler, M.D. Specialty Group Delegates from Florida: Robert J. Brennan, M.D., representing Allergy, and Thomas D. Bartley, M.D., representing Thoracic Surgery, have participated in our caucuses and been a positive influence in enhancing Florida's overall strength in the House of Delegates.

Particular note should be made that a number of FMA Officers and Board, and Officers of Component County Medical Societies have

attended the meetings and supported the efforts of your Delegation.

Florida's Delegation continues to enjoy a strong voice in the House of Delegates and several of our delegation hold important council and committee assignments: Burns A. Dobbins, M.D., Chairman, AMA Judicial Council; Rufus K. Broadaway, M.D., AMA Council on Long Range Planning and Development; Richard G. Connar, M.D., Member, Council on Medical Education. Several of our delegates have served on Reference Committees at the Annual and Interim Meetings of the House.

The number and gravity of the issues that continue to face organized medicine have been reflected in the large volume of issues to come before the House, issues that demonstrate all too clearly the ever present threats to the quality of medical care and our private system of health care delivery.

The following is a summary of the activities of your Florida delegation during the past year, including the Annual Meeting, June 22-26, 1979 in Chicago and the Interim meeting, December 2-5, 1979 held in Honolulu, Hawaii. Your delegates have submitted written reports on its activities at both meetings to the Board of Governors and to the FMA membership through FMA publications.

Candidates for AMA Elective Office: At the Annual Meeting last July, Florida was unsuccessful in its bid to have Florida AMA Delegate Joseph C. Von Thron, M.D., of Cocoa Beach elected to the Board of Trustees. Richard G. Connar, M.D., Florida AMA Delegate from Tampa, was re-elected for a three year term on the Council on Medical Education. All four incumbents whose terms expired in 1979 were re-elected: John J. Coury, Jr., M.D., Port Huran, Michigan; Frank J. Jirka, Jr., M.D., Barrington Hills, Chicago; Hubert A. Ritter, M.D., St. Louis, Missouri; and , Lowell H. Steen, M.D., Hammond, Indiana. Jack Lewis, M.D., of Ohio was elected to a 5th seat on the Board to fill the unexpired term of Trustee Robert B. Hunter, M.D., Washington, who was elevated to the office of President Elect in an uncontested election. Hoyt D. Gardner, M.D., Kentucky, was installed as the President of the AMA.

Florida AMA Delegates — Chairman and Vice Chairman: Your Chairman is grateful to my fellow Delegates for my re-election at the Annual Meeting in July to serve another one year term as Chairman of the Delegation. Dr. Joseph Von Thron was re-elected to serve another one year term as Vice Chairman.

House of Delegates Actions Re: Florida Resolutions

Florida Resolutions: Florida introduced three resolutions at the Annual Meeting. The following is a summary of the action taken regarding these resolutions by the House of Delegates.

Resolution 19 Access to Medicare Claim Payment Information

Adopted:

> RESOLVED, That the American Medical Association be commended for its adoption of Substitute Resolution 96 (I-78), "Access to Medicare Claim Payment Information," and that its constituent state medical associations be requested to support the AMA in the successful implementation of this policy.

Resolution 20 AMA Business Meetings & Scientific Sections

Not Adopted:

> RESOLVED, That the American Medical Association re-establish the policy that an AMA scientific session be held in the same city of both the annual and interim meetings of the House of Delegates on contigous and/or overlapping dates.

Resolution 21 Federal Funding for HSA's

Adopted as amended:

> RESOLVED, That the American Medical Association petition the United States Congress to eliminate or drastically reduce federal funding for health planning; and be it further
>
> RESOLVED, That the AMA actively encourage each constituent state medical association and every component county medical society to actively urge physicians to express this view in a positive manner to each member of the Congress of the United States.

Southeastern Coalition: The Board of Governors, at its meeting in October, authorized our participation in the Southeastern Coalition for one year provided that the AMA Delegates concurred and that it would not be at any additional expense. We considered this matter at our caucus at the Interim Meeting and heard a presentation from Dr. Jim Davis, who currently serves as Chairman of the Coalition. I am pleased to advise that the Delegates voted unanimously to participate for one year, beginning with the 1980 AMA Annnual Meeting. Your Delegation feels there are many positive gains that can be derived from a combined effort in addressing the many issues that are of mutual concern to members of the group, which includes the following states: Alabama, Delaware, Georgia, Louisiana, Maryland, Mississippi, South Carolina, North Carolina, Virginia and now, Florida. The total number of voting Delegates in the Coalition, including Florida, is 36. In addition, Tennessee and the District of Columbia have been invited to participate.

House Actions of Major Importance

National Health Insurance: At its meeting in July, the House of Delegates considered Reports N and XX of the Board of Trustees and seven resolutions regarding the AMA's national health insurance policy. .

The Board of Trustees' Reports related to the activities of the AMA in implementing Resolution #62 adopted at the 1978 Interim Meeting of the House. These reports recommended that the House concur with the implementation of Resolution #62 as finalized in the reports, including the need for the AMA to continue to play an active role in further congressional consideration of national health insurance. The numerous resolutions submitted to the House called for varying degrees of opposition of enactment of any type of compulsory national health insurance bill. The House adopted Reports N and XX of the Board of Trustees and reaffirmed Resolution #62 (I-78). The numerous resolutions introduced regarding NHI were not adopted.

At its recent Interim Meeting, national health insurance generated little debate. The House reaffirmed principles included in Resolution #62 as adopted at the 1978 Interim Meeting. The House authorized the Board to continue current initiatives to insure that the principles are forcefully articulated in any national health insurance proposals being considered by Congress. The House did direct the AMA to publish and distribute to delegates, a position paper entitled, *"Health Insurance: What Should I Buy?"* presented by Dr. Michael Smith of Louisiana. The House also adopted a resolution that the AMA continue to advocate the supervision of a voluntary free choice of health care delivery opposed to one dominated or controlled by the federal government.

AMA Budget and Membership: The House adopted a proposed budget for fiscal 1980 based on expected revenues of $62,525,000 and anticipated expenses of $55,559,000 with the balance going into reserves in accordance with House policy.

It should be noted that at the current level of AMA activity and projected rates of inflation, AMA expenses will begin to exceed income by 1981, barring dramatic changes in the current membership. The current ratio of AMA members to the United States physician population continues to decline. Also, 42% of the state societies and 63% of county medical societies have no membership recruitment programs. The Council on Long Range Planning and Development is studying various proposals for restructuring the AMA membership. Your Delegation's concern with the continuing decline in AMA membership has bee related to the Board of Governors along with a summary of those membership proposals currently being considered.

Principles of Medical Ethics: The report of the Ad Hoc Committee on the Principles of Medical Ethics was submitted to the House of Delegates at the 1979 Annual Meeting. The report and proposed principles are the result of extensive study directed at achieving the appropriate ethical stance of the medical profession in contemporary society.

The report included five recommendations. Recommendation #3 was adopted and referred to the Council on Constitution and Bylaws for report at the 1979 Interim Meeting. The House directed that the remainder of the report be distributed to state medical associations, component county medical societies and specialty societies for consideration by their respective House of Delegates. The House asked for the final report at the 1980 Annual Meeting.

Your Delegates recommended to the Board of Governors that the Report and Recommendations of the AMA Ad Hoc Committee on the Principles of Medical Ethics submitted for consideration at the 1979 AMA Annual Meeting be referred to the FMA Judicial Council for consideration and recommendations back to the Board prior to the 1980 FMA Annual Meeting in order that the Association's position regarding the proposed principles may be transmitted to the AMA for consideration at the 1980 AMA Annual Meeting through Florida's AMA Delegates or other appropriate mechanism.

Continuing Medical Education: The House of Delegates voted to drop its membership in the Liaison Committee on Continuing Medical Education, thereby reverting to its role as primary accreditor for CME sponsoring organizations. The action recognizes state medical associations as accrediting bodies for institution and organizations providing local and intra-state CME programs.

At the Interim Meeting, the House filed a report on future directions for medical education which proposed sweeping changes in medical education and directed that these suggestions become an agenda for discussion to be followed by the development and review of more specific recommendations. Issues addressed by the report ranged from attendance to medical school to residency training and licensure and physician evaluation. It suggests the need for restructuring of the third and fourth year in medical school, a comprehensive residency program, and the establishment of a committee on public and professional statesmen to make policy recommendations to the Council on Medical Education.

Chiropractic: The House of Delegates acknowledged and affirmed the authority of the Board of Trustees to settle a lawsuit involving chiropractic in Pennsylvania. The House also determined that the AMA should continue to warn the public of the hazards of health of entrusting the diagnosis and treatment of such human ailments as essential hypertension, heart disease, stroke, cancer, diabetes and infections to practitioners who rely upon the theory that all disease is caused by the misalignment of the spine.

The House adopted Report UU of the Board of Trustees regarding the position of the AMA on chiropractic, and relationships between physicians and chiropractors. The report adopted by the House recommends against the use of the term "unscientific cult" for describing chiropractic and proposed calling attention to the limitations of chiropractic. The report reaffirmed the medical viewpoint that chiropractic theory is unsupported by scientific evidence. Under the new policy, the AMA will continue to warn the public of the hazards of relying on spinal manipulation to treat human ailments. The policy preserves the right of the physician to choose those persons from whom he or she will accept patients.

Second Surgical Opinions: The House reaffirmed policy adopted at the 1978 Interim Meeting that patients and physicians have the right to seek a second surgical opinion freely from the physician of his or her choice. The House opposed the concept of mandatory second opinions and financial penalties by third party payers for not obtaining a second opinion. Further, that when a second opinion is required, it should be at no cost to the patient.

M.D. — Extender Supervision: The definition of supervision of physician extenders was heavily debated during the Annual Meeting and a report adopted clarifying the definition. "It shall be the policy of the AMA that the personal presence or participation by the supervising physician is the Physician Extenders activities where the services are rendered should be the standard of care in the usual practice settings. In unusual practice settings, exceptions to the standard should be determined and a specific waiver granted by the State Board of Medical Examiners on an individual case basis."

The Council on Medical Services was requested to continue study and re-evaluation of physician extender programs.

Federal Trade Commission: The House endorsed aggressive defense by the AMA in the proceedings brought against it by the FTC and litigation against the FTC to continue the efforts of the agency to invalidate legislation passed by state legislators.

Cost Containment: The House reaffirmed its commitment to a program of voluntary restraint of physician fee increases which asks M.D.'s to moderate the rate of fee increases by 1% for each of two years. The House continued to recognize that a structured but voluntary cost containment program will meet objectives of reducing escalation of health care costs without the inflationary effect of further government regulation. The House also noted that any cost containment program should not withhold necessary medical care or restrict medical research.

PSRO: The House urged continued efforts to enact amendments to the PSRO law to insure that care provided to patients is of high quality, appropriate duration and rendered in appropriate settings at reasonable cost. A resolution calling for the AMA to seek to have funding for PSRO excluded from the national budget was disapproved.

Health Planning: The House adopted and directed wide distribution of a report on Public Law, 96-79, modifications to Public Law 93-641, The National Health Planning and Resource Development Act. It was pointed out that the new law contains features even more noxious than the original law, including the invasion of the private practice of medicine and effectively extends certificate of need rules to physicians' offices.

Foreign Medical Graduates: The House revised a final report of the AMA Ad Hoc Committee on Foreign Medical Graduates Affairs. As reworded, the recommendations concerning Americans in overseas medical schools urges that they continue to be allowed to transfer with advanced standing into U.S. medical schools and that U.S. students considering attendance at foreign medical schools be provided with information enabling them to assess the difficulties and consequences associated with matriculation there.

Delaney Clause (FDA): The House adopted a report calling for revision of the Delaney Clause to provide that:

1. Risk benefit assessments be made in part of the decision making process;
2. Alternate risks be weighed before requiring the banning of a substance suspected of being hazardous; and
3. Decision-making on food additives should be based upon the best scientific evidence available pertaining to the usefulness, function, uniqueness, health needs and potential risk of substance.



Dr. Kevin P. Phillips of Bethesda, Md. (center) spoke at the Auxiliary-FLAMPAC Luncheon. With him are Mrs. B. David Epstein, Key Biscayne, President of the Auxiliary, and T. Byron Thames, M.D., Orlando, FMA President-Elect.

Medicare: Among the problems related to the Medicare program addressed by the House was the use of the phrase "reasonable charges" in the guide to Medicare recipients. The House adopted a resolution condemning use of the phrase when it misleads patients. It was noted that the guide does not discuss why the reasonable charge is often lower than the actual charge made by the physician and there is strong inference that a physician who does not accept assignment nor Medicare's reasonable charge as full payment is therefore making unreasonable charges. The House also adopted a resolution aimed at speeding Medicare reimbursement to physicians.

Blood Banking: The House adopted a resolution calling on the AMA to re-evalute its membership in the American Blood Commission if that group does not revise its 1977 action advocating a singular approach to blood collection. The House reaffirmed the AMA policy favoring multiple approaches to the collection of blood.

Other Actions: In other actions, the House:

— endorsed a major campaign to reduce cigarette smoking
— adopted a series of guidelines for coronary bypass surgery
— adopted an emergency resolution calling on the AMA to explore a program to aid Viet Nam refugees known as "boat people"
— called on the AMA to advise the parents of young children to keep a 1 oz. bottle of syrup of Ipacec in medicine cabinets for use in the event of accidental poisoning
— encouraged the development of a variety of types of medical support groups in efforts to prevent or deal with mental problems among student physicians
— adopted a resolution urging support of CPT-4 and opposing use of ICD-9-CM for documenting and reporting physicians' services
— endorsed efforts to oppose TV advertising and programming aimed at exploiting children

FMA Speaker's Bureau

The motion of the Reference Committee that the report of the FMA Speaker's Bureau be adopted as presented carried.

FMA Speaker's Bureau

Edward R. Annis, M.D., Chairman

High visibility with favorable results continues to be the positive story of the statewide Speaker's Bureau composed of elected officers and the Board of Governors.

The public and, in a number of instances, physicians and their wives have demonstrated the value of personal contact in spreading the positive story of organized medicine. During the past year topics discussed have included the background of litigation involving the Florida Medical Association, statewide peer review, the Florida Physician's Insurance Reciprocal as it has developed to deal effectively with the ever-present problem of professional liability, and nutrition and life-styles relative to the cost of medical care.

Statewide groups representing primary school teachers, secondary school teachers, secondary school principals, and school administrators were addressed during annual sessions. Two statewide insurance organizations representing multiple casualty and life companies were given an insight into malpractice problems as well as enlightenment on the multiple contributing costs to the escalation of health care.

Committee on County Medical Societies

The motion of the Reference Committee that the report of the Committee on County Medical Societies be adopted as presented carried.

Committee on County Medical Societies

Joseph P. Hendrix, M.D.

The Committee on County Medical Societies held two meetings during the past Association year — September 8, 1979 and January 27, 1980. The following is a summary of the Committee's activities. The Chairman wishes to thank the members of the Committee for giving of their time to serve on the Committee and for their interest in enhancing better understanding and communications between FMA and its component county medical societies.

Committee Responsibilities: The Committee on County Medical Societies is responsible for reviewing the ongoing activities and programs of the FMA, including public relations and legislative activities, liaison and communications with FMA component county medical societies and to make recommendations for improvements where needed. The Committee also makes recommendations for the program at the FMA Leadership Conference.

1980 FMA Leadership Conference: The Committee recommended to the Board of Governors that the format for the 1980 FMA Leadership Conference be generally the same as that followed in 1979 with the suggestion that topics for discussion include local, state and AMA membership recruitment, programs and public relations with special emphasis on successful communications and liaison with the news media, and also a seminar on negotiations to be held in conjunction with the Leadership Conference. The format of the Leadership Conference generally reflected these proposals and a negotiations seminar was scheduled for March 22-23, 1980 in Central Florida.

FMA Priorities and Activities: The Committee reviewed in detail the FMA Priorities for 1979-80 and current programs and activities. The Committee related to the Board of Governors its observation that the 1979-80 Priorities adopted by the Board of appear to reflect programs and activities with respect to public, membership and issues that are of primary concern to physicians. The

Committee did however, express a need for the FMA to provide guidance to county societies in dealing with the issue of the cost of medical care, specifically as to how to most effectively deal with the physician who consistently overcharges.

There was also concern expressed that there are an undetermined number of physicians who had not fulfilled their CME requirements within their required cycle and who at the end of 1979 were in jeopardy of losing their membership in both the FMA and the county medical society. It was generally agreed that physicians have both the responsibility and ample opportunity to meet their CME requirements within the cycle. The Committee recommended to the Board of Governors that consideration be given to including total CME hours completed on the application for renewal of PLI coverage under the Florida Physicians' Insurance Reciprocal and that this be a factor considered in approval or disapproval of coverage.

Florida Physicians Association, Inc.: The Committee reviewed the purposes and activities of the Florida Physicians Association. It was noted that as a result of the failure of the FPA to be recognized as a collective bargaining agent and because of its inactivity, a local chapter of the Florida Physicians and Dentists Union had been formed in Broward County.

The Committee recommended to the Board of Governors that a careful evaluation be made of the purposes and activities of the Florida Physicians Association and that guidance be given to the FPA as to its appropriate role in representing physicians in dealing with third parties in the face of increasing activities by independent organizations such as the Florida Physicians and Dentists Union which is a recognized collective bargaining agent for its members.

Standardized Membership Application Form: On recommendation of the Committee, the Board of Governors approved in principle the FMA offering to make a standardized membership application from available to county medical societies that can be utilized for CMS and FMA membership. At the Board's direction, the form has been sent to county societies for any comments prior to the finalized form being presented to the House of Delegates for approval at the 1980 Annual Meeting.

Liaison with County Medical Societies: In oder to carry out its responsibilities in reviewing the effectiveness of the ongoing programs of the FMA and its relationships with component county medical societies, the Committee felt that it would be productive to rotate its meetings within the state's four medical districts and to invite representatives from surrounding county medical societies to participate. Therefore, the Committee requested authorization to hold two additional meetings during the current Association year. Due to budget restraints, regional meetings of the Committee were not approved. However, the Board requested that the Committee meet with representatives of county medical societies during the time of the FMA Leadership Conference. This was done and a large number of CMS representatives attended. The Committee felt the meeting to be highly productive. Topics discussed included: Peer Review, the FMA Legislative Program, FMA Visitation Program, Florida Health Data Corporation and other issues.

Liaison with County Medical Society Executives: The Board of Governors had referred the question of organization and functions of county medical society executives to the Committee for review and recommendations as to an appropriate manner of liaison with county society executives.

The Committee commended the desire of the county medical society staffs for improved communications and expanded knowledge in their important work and recommended to the Board of Governors that the County Medical Society Executives Conference be recognized and that staff ties between the FMA and component county medical societies be strengthened.

The Committee noted, however, that while the county medical society executives should have an adequate level of input into the activities of FMA, it is primarily the responsibility of the Committee on County Medical Societies to insure improved communication and liaison with individual county medical societies.

Committee on Health Regulatory Activities

The motion of the Reference Committee that the report of the Committee on Health Regulatory Activities be adopted as presented carried.

Health Regulatory Activities

Jack A. MaCris, M.D.

As we begin the decade of the 80's, somber reality learned from the 70's is that the Federal Government, primarily through the Federal Trade Commission and the Justice Department, is attempting to control and police the medical profession and its membership organizations. The 70's saw the Federal Trade Commission make a direct assault on the ethical foundation of our profession. This assault was made possible by a decision of the United States Supreme Court which broadened the application of the Sherman Antitrust Act to the professions. We are encouraged to note that the Congress of the United States is currently investigating and considering the role of the Federal Trade Commission in regulating professions. It is apparent that Congress is becoming increasingly aware of the fact that the Federal Trade Commission has in many instances overstepped its intended congressional authority. We are hopeful of favorable results from this congressional concern and have offered and given our assistance to the AMA in its efforts to have this legislation adopted.

In living with this reality as we enter the 80's we must not deter ourselves from the standards of conduct that have served our noble and honorable profession. Medicine must meet the public's demand for new accountability that physicians and their organizations are acting for the general good and not purely for professional self interest. This is a vexing challenge that requires medical leaders to achieve an understanding of those activities of our organization that potentially could impact on us in the form of federal investigation or challenge. Summations of the various federal activities that have either challenged the Florida Medical Association directly, or investigated its activities are reported to you in the Board of Governors report found elsewhere in this handbook. I urge your review of those investigations as examples of some of the areas of interest of various federal agencies.

Additionally, we must take note of the various federal agencies and the scope of their interests which has been documented by speeches and writings from their attorneys and officers. As an example, it would appear to us that the Federal Trade Commission will be scrutinizing the Joint Commission of Accreditation of Hospital standards. Another area for FTC involvement is the "captive laboratories" owned by physicians who funnel their patients for lab services. The FTC has already been active in the Opthalmic field. We can expect more activity, particularly with respect to dispensing of glasses. Another area of further FTC activity will be on behalf of those physicians and limited practitioners who seek, but cannot get hospital privileges and consider themselves victims of an antitrust "boycott".

All of this activity requires us to formulate responsible policies that neither restrain trade nor advocate the medical professions traditional concern for quality care. Leaders of organized medicine must make decisions that serve the profession and certainly consider the public interest.

Ad Hoc Committee on Impaired Physicians

The motion of the Reference Committee that the report and recommendations of the Committee on Impaired Physicians be adopted as presented and

referred to the Board of Governors for implementation at such time as the Board is of the opinion that a) appropriate legal and statutory provisions exist to protect the confidentiality of records, and b) adequate funding is available for implementation, and that progress on the development of this important program be reported by the Board to the House of Delegates at its next meeting carried.

Ad Hoc Committee on Impaired Physicians

Joseph G. Matthews, M.D., Chairman

The 1980 Annual Report of the Ad Hoc Committee on Impaired Physicians will summarize the major areas of activity that occupied the Committee's time and energy since its creation by the Board of Governors in June 1979. The Board of Governors charged the Committee to study and make recommendations regarding the establishment of an on-going statewide Impaired Physicians Program. The Committee was also requested to seek the advice of the Florida Medical Association Auxiliary as to how they may be of assistance in developing the program. The action of the Board of Governors was in response to a resolution adopted by the House of Delegates in May 1979, wherein the House recommended the establishment of an on-going statewide Impaired Physician Program. The Committee membership is as follows: Joseph G. Matthews, M.D., Chairman, Orlando; Theodore J. Marshall, M.D., Pensacola; Vincent P. Corso, M.D., Miami. Auxiliary representatives to the Committee were Mrs. Mary Beth Weigand and Mrs. Edie Epstein. The Committee held meetings on September 22, 1979 and January 25, February 12 and March 1-2, 1980. The Committee had 100% attendance at all meetings. The Committee received voluminous literature and other information pertaining to other Impaired Physician Programs from around the country. In addition to the three regularly scheduled meetings, the representatives of the Committee did attend special seminars in Dade County and the entire Committee met at Ridgeview Institute in Atlanta on February 12, 1980, and devoted the entire day to conferring with representatives of the Georgia Medical Association's Impaired Physician Program. In addition, the members of the Committee have had direct contact with persons involved in rehabilitation programs and the Committee had a representative from the local Chapter of the International Doctors of Alcoholics Anonymous attend one of the meetings. In addition, the Committee has had direct contact with Doloris Morgan, M.D., the current Medical Director of the Rehabilitation Unit at South Miami Hospital. The Committee has solicited and received extensive literature from the American Medical Association's Department of Mental Health and has had direct communication with the Medical Director of the Mississippi Association Impaired Physician Program. At the February 12 meeting at Ridgeview Institute we were able to have an extensive conference with Nancy Kelly Wittenburg, the Secretary of the Department of Professional Regulation. This helpful dialogue will be necessary in developing our program. After extensive study and research, the Committee, on March 4, 1980, made its formal report and recommendations to the Board of Governors for their consideration.

RECOMMENDATION NO. 1

THAT THE FLORIDA MEDICAL ASSOCIATION ESTABLISH, FINANCE AND UNDERTAKE TO IMPLEMENT A *STATEWIDE* IMPAIRED PHYSICIANS PROGRAM FOR PHYSICIANS WHOSE USE OF ALCOHOL OR OTHER CHEMICAL SUBSTANCES MAY INTERFERE WITH THEIR ABILITY TO PRACTICE MEDICINE.

RECOMMENDATION NO. 2

THE COMMITTEE RECOMMENDS A STRUCTURED PROGRAM THAT WILL BE SUPPORTIVE, REHABILITATIVE, NON-PUNITIVE.

RECOMMENDATION NO. 3

THAT THE FLORIDA MEDICAL ASSOCIATION ESTABLISH A PHASED PROGRAM, ORGANIZED IN A SYSTEMATIC MANNER AS FOLLOWS:

A. THE ESTABLISHMENT OF A STANDING PERMANENT STATEWIDE COMMITTEE WITH BROAD BACKGROUND AND BROAD GEOGRAPHIC DISTRIBUTION WITH FMA AUXILIARY REPRESENTATION.
B. THE FMA EMPLOY A MEDICAL DIRECTOR WITH EXPERTISE IN THE FIELD OF ALCOHOLISM OR AN ADDICTIONOLOGIST AND THAT HE CAN BE HIRED AS A FULL-TIME OR PART-TIME EMPLOYEE.
C. ESTABLISHMENT OF A "HOT TELEPHONE LINE" WITH SUPPORTING CLERICAL STAFF AND A PUBLISHED ADDRESS TO RECEIVE CALLS AND INFORMATION REGARDING IMPAIRED PHYSICIANS.
D. AFTER THE ABOVE STEPS HAVE BEGUN, THE COMMITTEE AND DIRECTOR WILL ESTABLISH CONFRONTATION TEAMS AND APPROPRIATELY EDUCATE THESE TEAMS. THE TEAMS WILL BE USED TO CONTACT THE IMPAIRED PHYSICIAN AND ENCOURAGE HIM TO SEEK REHABILITATION VOLUNTARILY. THE COMMITTEE WILL ALSO VERIFY COMPLIANCE.

RECOMMENDATION NO. 4

THAT THE JUDICIAL COUNCIL OF FMA ADOPT A POLICY STATEMENT AND PROCLAIM IT THE ETHICAL RESPONSIBILITY OF ANY PHYSICIAN WHO BECOMES AWARE OF AN IMPAIRMENT IN A COLLEAGUE TO SEEK TREATMENT OR REHABILITATION FOR HIS FELLOW PHYSICIAN.

RECOMMENDATION NO. 5

THAT THE FLORIDA MEDICAL ASSOCIATION BUDGET AND ADEQUATELY FUND THE IMPAIRED PHYSICIAN PROGRAM.

Footnote:

The Board, pending identification of availability of funds by the FMA Executive Committee, approved in principle and referred the Committee's report and recommendations to the House of Delegates. It was noted that funds are not currently available for implementation of this program.

Florida Medical Foundation

The motion of the Reference Committee that the report of the Florida Medical Foundation be adopted as presented with the exception of those items referred to other Reference Committees carried.

Florida Medical Foundation
Eugene G. Peek Jr., M.D., President

The Florida Medical Foundation continues to play an important role in Florida Medicine through its many activities. The Board of Directors of the Foundation met regularly in conjunction with meetings of the FMA Board of Governors. The following is a summary of the Foundation's activities during the past year.

Programs — The Foundation serves as administrator for a number of programs. Currently these include Peer Medical Utilization Review, the Student Loan Program, AMA Jail Project, Neonatal Intensive Care Program, Medical Seminars, Continuing Medical Education Accreditation, and the Scientific Speakers Registry.

Peer Medical Utilization Review (PMUR) — Peer Medical Utilization Review has been a very controversial area during the past year. Concerns expressed by several county medical societies have resulted in a complete internal analysis and evaluation of the peer review process and the operating procedures. Many improvements were made in the process.

It was also learned through this evaluation that better communications with the county medical societies are essential. The State Committee has received approval from the Board to conduct a workshop on PMUR for members of local committees, county society officers, and staff during the 1980 Annual Meeting of the Florida Medical Association. A series of articles on PMUR will also be written for publication in *The Journal of the Florida Medical Association*. A presentation on PMUR was made to the Committee on County Medical Societies and the County Medical Society Executives.

As has been the custom for several years, representatives from county medical societies were invited to each meeting of the State Committee on PMUR. The Chairman and staff met with the Board of one county medical society during the year and made the commitment to meet with any county medical society upon request. The overall objective of the Committee for the coming year is to strive to improve the understanding about PMUR insuring consistency and equity in the PMUR process.

The Committee on Peer Medical Utilization Review met several times during the year on May 21-22, 1979, September 14-15, 1979, January 4-5, 1980, February 29-March 1, 1980, and May 6-7, 1980, immediately prior to the FMA Annual Meeting.

The Committee conducted forty-nine (49) initial reviews and twenty-two (22) peer review appeals. In addition, the Committee conducted fifteen (15) health insurance appeals.

The Committee feels that its activity in PMUR has been one of the most meaningful efforts undertaken by the Foundation. Since the program began in 1972, there have been 794 physician cases referred to PMUR.

FMF Medical Education Committee — The Committee on Medical Education during the past year has continued to focus its efforts in two principal areas: (1) working as an accredited co-sponsor of continuing medical education programs in Florida; and (2) refining and maintaining the Scientific Speakers Registry. Activities and progress in these two areas are summarized below:

1. **Accredited Co-sponsorship Program** — The FMF Medical Education Committee is one of about 25 organizations and institutions in Florida accredited for continuing medical education by the American Medical Association. It is the only one in the state functioning both statewide and in virtually every specialty. The Committee is unique in that it does not unilaterally sponsor continuing medical education activities. Rather, it joins other providers as an "accredited co-sponsor", and in this role it assures quality and certifies Category I credit for those offerings that meet the criteria.

This program has grown as it has become better known among hospitals and medical organizations in Florida. In 1977 it began accepting applications for co-sponsorship on July 1, and from that time to the end of the year, it accepted only seven applications.

This grew to 16 applications in all of 1978, and to 31 in 1979.

Of the 31 applications for co-sponsorship received during 1979, one is still pending and two were withdrawn. Twenty-eight (28) applications were approved, and they represented 490 hours of Category I credit in Florida. Some of these programs were ongoing and the Committee approved up to an entire year of weekly or monthly programs on one application.

So far in 1980 (from January 1 to February 21), the Committee has received four applications for its assistance. Three of these have been approved for a total of 40 hours in Category I, and one appplication is still pending.

Your Committee is of the opinion that this is a valuable program for FMA members, and the Committee members have found it worthy of the considerable amount of time they have devoted to it.

Further growth in the co-sponsorship program is anticipated.

2. **Scientific Speakers Registry** — When the Scientific Speakers Registry was first established, county medical societies, specialty groups and hospital medical staffs were queried for volunteers. The names of all volunteers were referred to the Florida Medical Association's Council on Scientific Activities for review and clearance prior to their inclusion in the Registry. Most names were unknown to members of the Council. While in releasing names of registrants upon request by program directors, the Foundation disclaimed any endorsement. It was felt that the very fact that the names were provided by the Foundation might imply endorsement.

Operation of the Registry was suspended temporarily while a system of better review and evaluation was devised. Each physician previously registered was sent a new application form requesting more information about his professional education and background. As these forms were completed and returned, a roster was formulated and sent to each member of the Committee on Medical Education. Committee members were asked to indicate whether they are personally acquainted with each registrant or his work; and to recommend what level of peer evaluation should be made.

As a minimum, each name of a volunteer was sent to his county medical society for review. Depending on the feedback from both Committee members and county medical societies, applications were subject to further review by the appropriate specialty groups and/or hospital medical staffs.

All of this material will be reviewed by the Committee on Medical Education prior to submission to the Council on Scientific Activities later this year.

The revised roster of volunteer physicians includes about 180 names.

Medical Student Loans — The Foundation has a Student Loan Program administered through the Florida First National Bank of Jacksonville with the Foundation serving as guarantor. The Program continues in a moratorium status until sufficient loans have been repaid to remove the serious threat to the solvency of the Program.

Progress continues to be made to improve the status of the student loan program. Since the last Annual Report, the number of in-school loans has been reduced from thirty (30) loans with a loan balance of $79,470.68 to fifteen (15) loans with a loan balance of $41,674.38. There are seventy-three (73) loans in a repayment status which totaled $200,871.41 with a remaining balance of $111,924.98. This is a reduction from last year of eighty-two (82) loans totaling $208,111.87 and a remaining balance of $121,100.91. The Foundation as guarantor has paid eleven (11) loans totaling $37,383.84 with an uncollected balance of $32,207.84 and is actively pursuing the collection of these defaulted loans. One physician declared bankruptcy resulting in the Foundation paying off his loan of $4,804.59.

Nutrition Textbook — The Special Nutrition Issue of the FMA *Journal* published in April 1979 received such acclaim nationwide that it is being published in textbook form. Four new chapters have been

added along with a forward and the references updated. Arrangements have been made for publishing and marketing the book with royalties to be shared by the FMF, and Florida's three medical schools who are participating in this joint venture.

Auxiliary Cookbook — A number of years ago, the FMA Auxiliary published a cookbook entitled *"What's Cooking Doc?"* The book was a compilation of the favorite recipes of Florida physicians, leaders in government at the local, state, and national level, and other notable individuals. This was a highly successful project with funds from the sale of the book being donated to the Foundation. Negotiations are now going on to sell the copyright to the book with royalties from future sales going to the FMF.

Florida Physicians Association

The motion of the Reference Committee that the report of the Florida Physicians Association be adopted as presented carried.

Florida Physicians Association

David T. Overbey, M.D., President

The 1980 Annual Report of the Florida Physicians Association summarizes the purpose and major area of activity of this organization. Since the last report, the President of the FPA has reported to the Board of Governors an up-date summation of the financial status and major areas of concern of the Florida Physicians Association. During the last year the Executive Committee of the FPA has consisted of David T. Overbey, M.D., President; John A. Dyal, Jr., M.D., Vice President; Warren M. Barrett, M.D., Treasurer; H. Quillian Jones, Jr., M.D., Secretary; James T. Cook, M.D., Immediate Past-President; Charles J. Kahn, M.D., FMA Representative; O. William Davenport, M.D., FMA Representative; and W. Mahon Myers, M.D., District Director.

During the past year the Florida Physicians Association has been monitoring various issues in which this organization could possibly involve itself. Basically, the Florida Physicians Association was set up to undertake activities that the FMA could not do because of Charter restrictions, or possible legal ramifications. Areas in which the Board of Directors of the Florida Physicians Association have looked into as activities which could possibly be undertaken are bargaining agents for its members with third parties, including governmental agencies and litigation which it might enter into individually or with other organizations. The Florida Physicians Association has now reached a point where its involvement in such activities could be economically feasible. The Board of Directors of the organization is looking forward to the next year and will actively study any potential matter which this organization might involve itself. The organization is still attempting to expand its membership to include as many members of the Florida Medical Association as possible.

Judicial Council

The motion of the Reference Committee that the report of the Judicial Council be adopted as presented and that the AMA Delegates of the Florida Medical Association support amendments to the Principles of Medical Ethics which they determine appropriate was carried.

Judicial Council

James A. Winslow Jr., M.D., Chairman

The 1980 Annaul Report of the Judicial Council will summarize the major areas of activity that occupied the Council's time and energy since the last Annual Meeting of the Florida Medical Association, held in May of 1979. The Council's duties, functions, and composition are specifically prescribed in Chapter 8, Section 3 of the Florida Medical Association's Bylaws. Generally, it is the function of the Judicial Council to direct and supervise the activities of the Association which pertain to questions of medical ethics, descension, and disputes referred to the Association for investigation and adjudication, complaints by patients against members of the Association, and questions of membership and disciplinary action. The Bylaws of the Florida Medical Association further provide that the component county medical society shall be the basic unit for censuring, suspending, or otherwise disciplining its members. Any member subject to such action has the right to appeal to the Judicial Council, in the manner prescribed by the Bylaws. Since the last Annual Report of your Judicial Council your Chairman has reported to the Board of Governors up-to-date summations and recommendations relative to major areas of Council concern. Since the last Annual Meeting of the Association, the Council has met on the following occasions: May 23, 1979; August 25, 1979; and January 25, 1980. The current membership of the Council is as follows: James A. Winslow, Jr., M.D., Chairman, Tampa, Florida; Vincent P. Corso, M.D., Vice Chairman, Miami, Florida; Joseph H. Davis, M.D., Miami, Florida; Robert J. Brennan, M.D., Ft. Lauderdale, Florida; and O. Frank Agee, M.D., Gainesville, Florida. The Council has been staffed by Mr. John Thrasher, FMA Legal Counsel.

The Council's activities are summarized under the appropriate headings as follows:

1. **Policy Statement, Re: Advertising By Members:** Prior to the May, 1979 meeting, the Judicial Council and Staff undertook to review the numerous events that had taken place relative to professional advertising. These included decisions of the Supreme Court of the United States, Federal Trade Commission action against the American Medical Association and Rules and Regulations regarding physician advertising promulgated by the Florida State Board of Medical Examiners. It was the opinion of your Judicial Council that existing FMA ethical policies regarding advertising should be reviewed in view of the changing legal climate relative to professional advertising. Accordingly, the Judicial Council recommended a policy regarding advertising that encompassed the current ethical consideration relative to physician advertising that were evolving as a result of the recent legal events. This policy was adopted unanimously by the House of Delegates during the course of its May, 1979 meeting. After reviewing the situation over the last year, it is the opinion of the Judicial Council that notwithstanding the somewhat more liberal approach to this subject as taken by the above referenced policy, there does not seem to be a rush by physicians to newspapers, TV stations, radio stations and other types of media. It is the continuing belief of the Judicial Council that physicians on an individual basis have continued to recognize their personal responsibility in this area and have sought to maintain the highest degree of professionalism notwithstanding the court mandated liberalization of this field.

2. **AMA Principles of Medical Ethics:** During the past year the Council has been requested by the Board of Governors of the Florida Medical Association to review and report to the Board on certain proposed changes to the AMA Principles of Medical Ethics. The Judicial Council reviewed the proposal extensively and has reported to the Board its findings. Generally, the proposed changes, in the opinion of the Judicial Council, seek to place great emphasis of the responsibility of the individual physician in terms of medical ethics. It further appeared to the Judicial Council that the framers of the proposed Principles of Medical Ethics have sought to balance the goals of the profession and the long standing commitment to high ethical standards against the need for the individual physician to take on and assume more discretion and accountability for his or her conduct. With the general purpose in mind, the Judicial Council, as a general proposition,

recommended to the Board of Governors that the AMA Delegation support the proposed changes to the Principles of Medical Ethics.

3. **Liaison with the State Board of Medical Examiners:** During the past year the Florida Legislature extensively revised the role of the Board of Medical Examiners as it relates to physician discipline. Notwithstanding this now diminished role of the Board in this area, it is the Council's opinion that it must continue to maintain a close relationship with the Board and establish even greater liaison with the new members of the Board. Accordingly, the Council is anticipating in the very near future of attempting to hold a meeting concurrently with a meeting of the Board of Medical Examiners. Additionally, it should be noted that discussions and negotiations have been initiated to establish a formal relationship between the Department of Professional Regulation and the Florida Medical Foundation that would allow an appropriate committee of the Foundation, e.g., the Membership and Discipline Committee of the Judicial Council to review and make recommendations on complaints filed against physicians that require professional medical review.

4. **Grievances:** During the past year the Council has noticed an increase in the number of grievances that it has been presented with. The Council has continued to maintain its procedures of allowing county medical societies to resolve these local grievances and report their findings to the individual with copies to this Council. The Council, pursuant to the Bylaws of the Florida Medical Association, has the responsibility for reviewing decisions of county medical societies wherein one of the parties so requests. This system has worked efficiently and the Council encourages each county medical society to process and finalize decisions on grievances in an efficient, fair and expeditious manner. During the course of the year questions have arisen relative to the fundamental aspects of procedural due process in handling grievances involving physician members. In reviewing most of these questions, it has been determined that generally speaking, county medical society bylaws contain the necessary provisions to afford procedural due process to an individual accused of unethical conduct. It is essential that the county medical society not disregard the procedural safeguards enacted in their Bylaws and/or Charter. Several basic criteria for procedural process are outlined as follows:

A. The charged member should be informed in writing of a statement of charges to which he is being asked to respond;
B. The charged member should be given notice of the time and place of a proposed meeting to review the charges;
C. The charged individual should be afforded the opportunity to appear in person before the appropriate committee and defend against the charges.

5. **Impaired Physicians Program:** The Judicial Council, during the first part of 1979, had been charged with the responsibility of researching how the Florida Medical Association should appropriately respond to the impaired physician problem. After much deliberation and research by the Council, it was the opinion of the Council that the Board of Governors should establish an Ad Hoc Committee of the Board to be charged with the responsiblity of recommending to the Board an appropriate program for the Association, relative to impaired physicians. It is noted that the House of Delegates adopted this recommendation and appointed an Ad Hoc Committee which we understand has made a formal report and recommendation to the Board.

6. **Opinions of the Judicial Council:** During the past year the Council rendered or adopted the following opinions:

Opinion 79-1 — (This opinion was formulated as a part of the Policy Statement, Re: Advertising By Members, adopted by the House of Delegates — May 1979). It shall not be considered unethical for a physician to permit dissemination to the public of legitimate, factual and undistorted information in accordance with the policy of the Florida Medical Association, Re: Advertising By Members, regarding the practice of medicine and where and from whom health services may be obtained, so long as such information is in no way fraudulent, false, deceptive or misleading. Any advertisement, or advertising, shall be deemed to be fraudulent, false, deceptive, or misleading if it:

A. Contains testimonials;
B. Is intended or likely to create inflated unjustified expectations of favorable results;
C. Is self laudatory or implies that the physician, or groups of physicians, or a specific office, clinic, or center has skills superior to other physicians, offices, clinics or centers;
D. Contains incorrect or incomplete facts or representations or implications that are likely to cause the average person to misunderstand or be deceived.

RESOLUTION 80-2
Museum for Medical History
Duval County Medical Society

The Reference Committee heard testimony in support of Resolution 80-2. A delegate from the Dade County Medical Association had requested that the Alamo in Miami also be designated as a museum of medical history in Florida.

The motion of the Reference Committee that Resolution 80-2, along with the recommendation from the delegate from Dade County, be referred to the Board of Governors for study and recommendations back to the House carried.

RESOLUTION 80-2
Museum for Medical History
[Not Adopted — Referred to the Board of Governors]

Whereas, Old St. Luke's Hospital was dedicated on February 24, 1878 and served the medical needs of Northeast Florida until January 26, 1914 when all the patients were transferred to the new St. Luke's, and

Whereas, This institution is the oldest standing hospital building in Florida and it started the first Nurses Training School in the state in 1885 and graduated the first nurse in 1888, and

(a) the yellow fever epidemic of 1888
(b) the typhoid epidemic of 1898
(c) the great fire of 1901 which destroyed downtown Jacksonville, and

Whereas, Old St. Luke's deserves and awaits restoration; be it therefore

RESOLVED, That the Duval County Medical Society requests the Florida Medical Association to designate Old St. Luke's Hospital as a Museum for Medical History for Florida.

RESOLUTION 80-10
Bylaws Amendments — Osteopathy
Broward County Medical Association

The Reference Committee heard considerable discussion regarding the intent of this Resolution and had to request special information to enable it to fully interpret its intent.

The motion of the Reference Committee that Resolution 80-10 be referred to the Board of Governors

for further review, investigation and clarification of its intent carried.

RESOLUTION 80-10
Bylaws Amendment
[Not Adopted — Referred to the Board of Governors]

RESOLVED, That the FMA Bylaws, Chapter 1, Section 1.2. be amended as follows:

"Any doctor of osteopathy who has satisfactorily completed an AMA approved internship and/or residency training program OR WHO HAS BEEN CERTIFIED BY A SPECIALTY BOARD RECOGNIZED BY THE AMERICAN BOARD OF MEDICAL SPECIALTIES may be accepted into membership in the Florida Medical Association, Inc., upon certification . . . ."

The Chairman expressed his appreciation to each of the members of the Reference Committee and Dr. Charles Donegan and Dr. Vernon Astler, AMA Delegates, for their diligent attention to the business of the House of Delegates. Appreciation was also extended to Miss Rita Gearhart, recording secretary, and FMA staff for their support of the Committee and the many members of the Association who attended the meeting to present testimony.

The motion of the Reference Committee that the report of Reference Committee III be adopted as amended carried.

The Speaker resumed the Chair and called for the report of Reference Committee No. V.



Dr. and Mrs. Richard S. Hodes

. . . As FMA President and First Lady . . .



. . . As Host and Hostess for the Friday evening Mardi Gras Spectacular

Report of Reference Committee No. V Medical Economics

Dr. Clarence M. Gilbert, Chairman and his Committee came forward to present the report of Reference Committee No. V, Medical Economics.

Report E
of the
Board of Governors

The Reference Committee was impressed with the actions contained in Report E of the Board of Governors and took favorable note of the portion pertaining to Worker's Compensation, and commended Dr. James F. Richards, Chairman of the Committee on Worker's Compensation, for his diligence and excellent work.

The Reference Committee pointed out that under the Committee on PMUR, the paragraph on PMUR Medicare should read October 1, "1979", not "1970".

The motion of the Reference Committee that Recommendation No. E-1 be adopted as printed in the Handbook carried.

The motion of the Reference Committee that Report E of the Board of Governors be adopted as corrected carried.

Report E
of the
Board of Governors
Richard S. Hodes, M.D., Chairman

1979 House of Delegates Referrals

Liaison Committee on Blue Shield — The House of Delegates adopted Substitute Resolution 79-29 — Change in the legal structure of Blue Shield. The resolve of this resolution provides:

1. That it is desirable and advantageous for both physicians and their patients that Blue Shield continue in its role as fiscal intermediary for the Medicare Part "B" in the State of Florida.
2. That the House of Delegates reiterate FMA support of Blue Shield as a cost effective health insurance plan and encourage its members to continue as Participating Physicians.
3. That the FMA House of Delegates approves a mutually agreed upon dissolution of FMA sponsorship of Blue Shield and the implementation of an orderly transition providing for the legal autonomy of Blue Shield of Florida.
4. That a liaison committee of the Florida Medical Association be established to develop an adequate and effective forum for continued inter-change between the organizations with special attention to the protection of the health insurance needs of the people of Florida.

In compliance with part four of the resolve, the Board appointed a Liaison Committee on Blue Shield to be composed of Dr. T. Byron Thames, Chairman and Dr. Thomas E. McKell. In addition, continuous dialogue and liaison has been maintained between the Executive staffs of FMA and Blue Shield. The Board also approved continued Blue Shield meeting activities during the FMA Annual Meeting including a general information meeting for FMA members.

Board Actions of Major Importance

1. Worker's Compensation — The House of Delegates at its meeting in 1978, requested the Board of Governors to establish a date



FMA members interested in reports and resolutions on Medical Economics attended Reference Committee No. V. Left to right: David S. Hubbell, M.D., St. Petersburg; Charles J. Kahn, M.D., Pensacola; Mrs. Marcia Protheroe, Recorder, Jacksonville; Clarence H. Gilbert, M.D., Chairman, Orlando; Robert B. Katims, M.D., Miami; and Arthur L. Eberly, M.D., Lighthouse Point.

by which time the Workers' Compensation Bureau should have accumulated sufficient data concerning worker's compensation fees to enable them to comply with the law and compensate at the usual and customary fee. The House directed that this date be reported to the House at its meeting in 1979, and that if the usual and customary compensation is not implemented by the date established by the Board that appropriate action be taken.

Dr. James Richards, Chairman of the Council on Medical Economics, made diligent efforts to bring about levels of reimbursement for physicians' services for worker's compensation at the usual and customary level. Since it was anticipated that action would be taken regarding the worker's compensation fee schedule during the 1979 Session of the Legislature, the Board concurred with the concensus of the Council on Medical Economics that no action be taken pending the outcome of activities by the Legislature, but that if nothing is done, a request for an increase be prepared.

The House thus directed that the FMA await the outcome of the 1979 Legislature and if no adjustment was made in the Worker's Compensation Medical Surgical Fee Schedule that a petition be initiated to request an increase in the fee schedule. The new Worker's Compensation law did not address the fee schedule so a petition was filed under the Florida Administrative Procedures Act on October 5, 1979. The petition requested recognition of three levels of office and hospital visits instead of one and a 35 percent across-the-board increase in the fee schedule

On December 10, 1979, a public hearing was held in Tallahassee to hear comments on the Association's petition. Testimony on behalf of the petition was presented with no opposition expressed at the hearing.

In March, the Association was advised that a rule had been promulgated by the Division of Worker's Compensation pursuant to the petition of the Association granting a 35% across-the-board increase in the Medical and Surgical Fee Schedule effective July 1, 1980. Additionally, three levels of initial and follow-up office visits, will be recognized as well as five levels of consultations.

This will mean an additional sixteen million dollars ($16,000,000) in payments to physicians during the next year. This amount does not truly reflect the impact of this increase because according to the Division of Worker's Compensation, many insurance carriers were already paying amounts above the fee schedule apparently due to the realization that the fee schedule was woefully inadequate although no information could be obtained to confirm this.

A copy of the new fee schedule will be provided to each physician by the Division of Worker's Compensation as soon as they are printed.

2. Florida Committee on the Cost of Medical Care (VE) — The Board received as information a report on the publication and distribution of a patient life-style brochure entitled, *"Your Life is in Your Hands,"* by the Florida Committee on Medical Care (Included in the Delegates' Packet). The Board commended the Committee for its efforts to provide physicians and the public with factual and educational information regarding the factors affecting the cost of medical care.

3. Florida PSRO Data Cooperative — The Board reviewed correspondence requesting the support of the FMA for the Foundation for Medical Care, Inc. Data Cooperative which was established by the Florida PSRO's for the development of an integrated data system in Florida. Current policy of the FMA prohibits the FMA from participating in any way in PSRO activities and leaves this to the discretion of the individual county medical societies. In addition, this is in direct conflict with the Florida Health Data Cooperation established by the FMA in cooperation with the Florida Hospital Association, the Florida Osteopathic Medical Association and the Florida League of Hospitals for the purpose of developing a health care data collection system controlled by the private sector.

RECOMMENDATION NO. E-1

THAT THE FMA REAFFIRM ITS SUPPORT OF THE FLORIDA HEALTH DATA CORPORATION WHOSE PRIMARY PURPOSE IS TO ESTABLISH AND OPERATE AN INDEPENDENT HEALTH DATA BANK CONTROLLED BY THE PRIVATE SECTOR.

FMA Councils and Committees

COUNCIL ON MEDICAL ECONOMICS

Joint Legislative Workshops — The Board authorized that a joint legislative workshop be established with the Florida Hospital Association, Florida League of Hospitals and the Group Practice Management Association to discuss the legislative priorities of the respective organizations in the area of economics in an effort to better coordinate legislative activities in Tallahassee.

FMA *"Briefs"* — The recommendation that hospital administrators and clinic managers be added to the mailing list for the FMA *"Briefs"* was approved and implemented.

Committee on Peer Medical Utilization Review

Alcoholic Rehabilitation Program — The Board expressed objection to the Department of HRS' regulation regarding the 21 day limitation coverage for Medicare for alcoholic rehabilitation. At the present time, Medicare allows for only 21 days coverage for alcoholic rehabilitation whereas most programs are currently designed for 28 day duration.

Operating Procedures — An in-depth review was conducted of the peer review program, and the Board approved amended operating procedures for PMUR to resolve concerns expressed by a number of county medical societies regarding iniquities in the program. It also approved the development of a reporting mechanism to enable county medical societies to identify and report physicians whose quality of care is suspect and who are currently not being identified through the PMUR process.

PMUR Workshop — The Board authorized a workshop on PMUR for county medical societies during the FMA Annual Meeting on Friday, May 9th, at 8:30 a.m. The purpose of the workshop is to discuss in detail the referral and review process. County societies are urged to take advantage of this opportunity to learn more about the peer review program.

PMUR *Journal* Articles — The Board authorized a series of articles on peer review to be published monthly in the FMA *Journal.*

PMUR Medicare — The Florida Medical Foundation was authorized to extend a contract with Blue Shield of Florida for the purpose of the performance of Peer Review in the State of Florida (except Dade and Monroe counties) for the period October 1, 1979 - September 30, 1980, and the contract between FMF and Group Health, Inc., for the purpose of the performance of Peer Review in Dade and Monroe counties, October 1, 1979 - September 30, 1980.

PMUR Medicaid — The Board approved an agreement between the Florida Medical Foundation and the State of Florida Department of Health and Rehabilitative Services for the FMF to provide Peer Review for Florida's Medicaid program from November 1, 1979 - October 31, 1980.

COUNCIL ON GOVERNMENT PROGRAMS

HSA Negotiations Training Program — The Board authorized a negotiations training program to be conducted in Florida for physicians involved with HSA's and other government programs, such program to be self-supporting, modeled after the one designed for the

Minnesota Medical Association by the Department of Negotiations of the American Medical Association.

Proposed 1979 Florida State Health Plan — The Board authorized the Committee on HSA's to establish specialty panels for the purpose of rewriting the following fascicles of the proposed 1979 Florida State Health Plan: Cardiovascular disease, cancer mental health, obstetric services, acute care beds and computerized tomography scanners.

United Fund — The Board brought to the attention of the President of the Dade County Medical Association that the United Fund has contributed money to support the Dade County HSA, as the FMA feels this is an inappropriate use of monies intended for charity.

HRS Fee Schedule — The Board gave legislative priority to seeking adequate funding of the Department of HRS Physician's Fee Schedule to insure sufficient providers to care for clients of the Department's programs and to maintain quality medical care.

HRS — Psychiatric Services — The Board supported continuation of the investigation into contracting for psychiatric services at state hospitals with regard to quality medical care in connection with the District Branches of the American Psychiatric Association.

Statewide Health Coordinating Council — It was recommended to the Statewide Health Coordinating Council, State Health Planning and Development Agency and Health Systems Agencies that all reports and position papers be properly documented including the name of the author(s).

Council on Medical Economics

The Reference Committee was impressed with the work of the Council on Medical Economics, chaired by Dr. James L. Borland Jr.

The motion of the Reference Committee that the report of the Council on Medical Economics be adopted as printed in the Handbook carried.

Council on Medical Economics

James L. Borland Jr., M.D., Chairman

The Council and Committee reorganization of 1979 greatly affected the activity of the Council on Medical Economics. There was some overlap in responsibility with the new Council on Government Programs because of the economic nature of some subject areas such as Workers' Compensation and Medicaid. The coordination between these two councils was handled very smoothly through the respective staff for each.

The Council Chairman served as President of the Florida Health Data Corporation during 1979-80, and a separate report of these activities is included elsewhere in the packet.

Committee on Relative Value Studies — The Committee on Relative Value Studies, Chaired by Joel W. Mattison, M.D., met twice during the year to discuss problems and questions about the 1975 Florida Relative Value Studies brought to its attention by members of the Association. The Committee also monitored the investigations of the Justice Department and the Federal Trade Commission into the use of Relative Value Studies. Discussions were held concerning updating the *1975 RVS*. The decision was made to wait until the federal government completed its investigation into relative value studies before pursuing this. It also was brought to the attention of the Committee that the Health Care Financing Administration is considering recommending the adoption of *Current Procedural Terminology Four* (CPT-4) as the uniform coding and descriptor system for reporting Medicare and Medicaid procedures. If this is adopted, it will require the Relative Value Studies to be revised so that the coding and nomenclature coincides with CPT-4.

Committee on the Cost of Medical Care — The Committee on the Cost of Medical Care is Chaired by John F. Lee, M.D., who also served as liaison to the Florida Committee on the Cost of Medical Care (Florida's Voluntary Effort Committee). This Committee has monitored very carefully the cost containment legislation, both in the State Legislature and the Congress of the United States. The National Voluntary Effort has made great strides in helping to contain the rising cost of medical care. This effort in 1978 and 1979 has saved more than three billion dollars in hospital costs alone. The Consumer Price Index published by the U.S. Department of Labor is used to measure changes in physician fees and in 1979, the physicians' services component increased 9.4% while the overall inflation rate was 13.3%.

The Voluntary Effort will continue through 1980 and the Committee continues to represent the Association in this important effort.

Committee on Medical Delivery Systems: Foundation/HMO — The Committee on Medical Delivery Systems: Foundation/HMO, Chaired by H. Phillip Hampton, M.D., of Tampa, was very active in 1979-80. With increased interest in Health Maintenance Organizations by both the federal and state government, the Committee has continued to monitor the development of HMO's in Florida.

The Committee is currently negotiating with the Department of Health and Rehabilitative Services to conduct a demonstration project for Medicaid. The present Medicaid program is a "crisis" oriented program encouraging emergency room and inpatient care which is the most costly medical care available. By improving preventive and outpatient services and through utilization review, the Committee feels that savings will occur which can be passed on to physicians in the form of more reasonable fees for services rendered. The Medicaid recipient will also receive "mainstream" medical care rather than second class care.

Committee on Administrative Medicine and Management — This newly-formed Committee is Chaired by Charlotte E. MaGuire, M.D., of Tallahassee. This Committee is unique in that it is composed of representatives of the Florida Hospital Association, Florida League of Hospitals, and Group Practice Management Association. At its initial meeting, the Committee recommended that improved communication with the representative organizations should be attempted. With the Board of Governors approval, the members of the respective organizations were added to the mailing list for general FMA publications.

A legislative workshop was also suggested to allow better coordination of legislative effort by the respective organizations. This was also approved by the Board and scheduled for March.

Council on Government Programs

The Reference Committee took note of the newly-created Council on Government Programs, chaired by Dr. Franklin B. McKechnie, and was favorably impressed by the activities of the Committees under this Council relating to Health Systems Agencies, Department of Health and Rehabilitative Services, Medicare and Workers' Compensation. The Reference Committee recognized the increasing importance of the ongoing functions of the Committee on Health Systems Agencies in its objectives of monitoring and influencing the actions of health planners under the National Health Planning and Development Act.

The motion of the Reference Committee that the report of the Council on Government Programs be

adopted as printed in the Handbook carried.

Council on Government Programs
Franklin B. McKechnie, M.D., Chairman

The Council on Government Programs has spent the first year of its existence monitoring the activities of: State Health Planning, Medicare, Workers' Compensation, and Medicaid, advising the FMA Board of Governors and making recommendations concerning these activities. The Council met in Orlando on September 22, 1979. Two telephone conference calls of the Council were held on January 3, 1980, and February 14, 1980.

Committee on Health Systems Agencies: During the past year the Committee on HSA's monitored the statewide implementation of P.L. 93-641 (the **National Health Planning and Development Act of 1974**) and P.L. 96-79 (the **Health Planning and Resources Development Amendments of 1979**). Particular attention was given to the activities of the Statewide Health Coordinating Council (SHCC), the State Health Planning and Development Agency (SHPDA), the Florida Association of Health Systems Agencies, Inc. and the nine Health Systems Agencies (HSA's). Members of the Committee on HSA's and FMA staff have participated in or been in attendance at all meetings of the SHCC, SHCC subcommittees and task forces. The Chairman of the Committee on HSA's, Paul J. Popovich, M.D., commented extensively with both written and verbal testimony on the **1979 Florida State Health Plan.** The Committee on HSA's in cooperation with affected specialty groups, is in the process of developing specialty panels for the purpose of rewriting the following fascicles of the **1979 Florida State Health Plan**: cardiovascular disease; cancer; mental health; obstetric services; acute care beds; and computerized tomography scanners. The Chairman of the Committee on HSA's met on February 21, 1980 with representatives of the Florida Hospital Association, the Florida Osteopathic Medical Association, the Florida Pharmaceutical Association, and the Florida Health Care Association for the purpose of developing a consortium of providers by Health Service Areas designed to monitor and work on local HSA problems.

At the invitation of the Committee, the Association co-sponsored with the American Medical Association's Department of Negotiations a successful seminar on the techniques of negotiation for physicians on March 22 and 23, 1980, entitled: *Introductory Seminar for Physician Negotiators: Dynamics of Conflict Resolution HSA Style.*

The Committee remains concerned that many physicians fail to realize the significance of health planning as implemented under P.L. 93-641 and P.L. 96-79. The Council reemphasizes the importance of the county medical societies' role in monitoring the activities of the HSA's especially as the HSA's undertake "appropriateness review" of services offered in local hospitals.

Committee on HRS: The Committee on HRS, through the efforts of its Chairman, Donald G. Nikolaus, M.D., monitored and participated in plans to reform the Florida Medicaid Program. The results of the Committee's efforts started to culminate on February 15, 1980, when the Department of Health and Rehabilitative Services presented to the Speaker of the House and President of the Senate a draft report entitled *The Medicaid Reform Study: An Interim Report.* The draft report takes into consideration many of the concerns expressed by the Committee on HRS and for the first time serious attention is being given to: the provision of preventive services for both adults and children; the provision of services when possible in an outpatient setting rather than an institutional setting; the need for improved reimbursement incentives to encourage prenatal care; the need for a "medical home" for Medicaid patients so that a personal physician can accept continual responsibility for the patient's medical needs; publication of a comprehensive *"Physician Services Reimbursement Manual"* which will include a fee schedule that clearly indicates which procedures are covered and the amount of reimbursement; a recommendation that the rate of implementation of increases in physician fees by phasing in to reach 100% of the 50th percentile be accomplished in four years rather than six years; the utilization of funds currently appropriated for FY '80-'81 as well as funds generated through displacement of general revenue be used to immediately increase physician fees in a manner which will target fee increases in areas which are most critical to achieving program reform priorities. Although it is too early to tell what the Legislature will do with *The Medicaid Reform Study,* it is encouraging to note that after so many years of being ignored, physicians, through the Committee on HRS, are playing an active part in influencing the formation of Medicaid policy.

Committee on Medicare: The Committee on Medicare is a new one-man committee established in 1979 and headed by Frank B. Hodnette, M.D. The Committee responded to several complaints about the Medicare Program by members of the Association. Investigations were made by staff and appropriate action taken as deemed necessary.

One major problem investigated by the Committee was the publication in the *Federal Register* of a regulation requiring that physicians give written notice to Medicare recipients that items or services furnished to him are not covered by Medicare or the physician could not bill the patient for the services. After research and communication with the American Medical Association, it was learned that this regulation was applicable to Medicare Part A and did not apply to physicians. The AMA advised that they were meeting with government representatives on this issue.

The Committee will continue to monitor the Medicare program and assist members with individual complaints and problems as they arise.

Committee on Workers' Compensation: The Committee on Workers' Compensation has had a very active year beginning with the 1979 Legislative Session. The Workers' Compensation statute was "sunset" under the Florida Sunshine Law which required the Legislature to rewrite the law in 1979. Through the efforts of Chairman, James F. Richards, M.D., and staff, the new law included a provision for peer medical utilization review and the establishment of a full-time position for a medical consultant. There has been no physician staff positions (full or part time) for several years.

Pursuant to the charge of the 1979 House of Delegates, which stated that ". . . if no satisfactory adjustment is made in the medical and surgical fee schedule . . ." by the 1979 Legislature, that a petition be initiated to request an increase in the fee schedule. The new Workers' Compensation Law did not address the fee schedule so said petition was filed under the Florida Administrative Procedures Act on October 5, 1979. The petition requested recognition of three levels of office and hospital visits instead of one and a 35% across-the-board increase in the fee schedule.

On December 10, 1979, a public hearing was held in Tallahassee to hear comments on the Association's petition. Testimony on behalf of the petition was presented with no oppposition expressed at the hearing.

In March, the Association was advised that a rule was promulgated by the Division of Workers' Compensation pursuant to the petition of the Association granting a 35% across-the-board increase in the Medical and Surgical Fee Schedule effective July 1, 1980. Additionally, three levels of office and hospital, initial and follow-up visits will be recognized as well as five levels of consultations. This will mean an additional sixteen million dollars in payments to physicians during the next year. This amount does not truly reflect the impact of this increase because according to the Division of Workers' Compensation, many insurance carriers were already paying amounts above the fee schedule. This apparently was due to the realization that the fee schedule was woefully inadequate although no information

could be obtained to confirm this.

The Committee anticipates continued work on the fee schedule in 1980, with plans to complete a detailed evaluation of the schedule to reveal the fee inadequacies of various sections. An analysis of the procedures and descriptions included in the schedule will also be made with recommendations for updating the terminology and procedures.

Contact has been made with the new Medical Consultant and discussions are under way to develop and implement a peer medical utilization review program for Workers' Compensation.

The Chairman also served as a member of the State's Advisory Committee for Workers' Compensation and attended several meetings of the Committee insuring medical input. The Chairman also served on the Hospital Fee Schedule Advisory Committee for the State and attended several meetings of this Committee.

Additionally, Dr. Richards served as Chairman of the 34th Annual Workers' Compensation Educational Conference held September 23-27 in Lake Buena Vista. Several hundred persons attended the five-day conference.

Supplemental Report
Council on Specialty Medicine
and
RESOLUTION 80-13
Medicare Reimbursement of Hospital-Based Physicians
Palm Beach County Medical Society

Since these two items deal with the same subject, the Reference Committee considered them at the same time.

The Reference Committee heard detailed commentary from many members of the Association with regard to regulations of the Medical Program which for fourteen years have not been enforced nor implemented. The Reference Committee expressed appreciation for the timely and current supplemental report from Dr. Dick Van Eldik, Chairman of the Council on Specialty Medicine, in regard to this matter. It was noted that the deadline for implementation of these regulations is short. It was further noted that the regulations do not contain a definition for the hospital-based physicians. The Reference Committee had been told that a request to the Health Care Financing Administration for a delay in implementation of these regulations has been made by the Medicare carriers of Florida and the Florida Hospital Association.

The Reference Committee noted that in the fifth paragraph of the Supplemental Report of the Council on Specialty Medicine, the date should be "March 21" not "May 21".

The motion of the Reference Committee that the Supplemental Report of the Council on Specialty Medicine be adopted as corrected carried.

Supplemental Report
Council on Specialty Medicine
Dick L. Van Eldik, M.D., Chairman

On Tuesday, March 11, the Department of HEW, Health Care Financing Administration, published in the Federal Register a rule advising that effective July 1, 1980 the HCFA would begin enforcing regulations regarding Medicare reimbursements for services furnished by hospital based physicians.

HCFA officials have said that the action reaffirms a rule established in a regulation published in 1966 as part of the regulations implementing the Medicare law but which has not been uniformly applied. In fact however, the AMA and representative national specialty groups, beginning as early as 1966, have over the years successfully challenged a number of attempts to implement these rules on the basis of their incongruity with the intent of Congress in implementing provisions of the Medicare law.

If implemented, the rule provides that identifiable professional services will be reimbursed under Part B on a reasonable charge basis only if:

A. The services require performance by a physician in person
B. They contribute to the diagnosis or treatment of the patient

All other services performed by a hospital based physician will be reimbursed to the hospital on a reasonable cost basis.

On March 21, HCFA issued a directive to Blue Cross and Blue Shield that effective on July 1, the Part B carrier should not reimburse the physician who bills directly for clinical laboratory services unless the billing is in compliance with the rules. In April, hospital administrators and physicians were advised of implementation of the rule.

On May 1, your Chairman along with other FMA, specialty group and Florida Hospital Association representatives attended an informational meeting held by Blue Cross/Blue Shield and officials of HCFA to discuss implementation of the rules. It soon became apparent that a great deal of confusion, uncertainty and lack of preparation exists regarding the rule and its implementation within such a short time frame as well as the issues raised, particularly on the part of HCFA and the carrier. There currently exists no clear-cut definition of a hospital based physician, what actions constitute personally performed services, nor established guidelines for dealing with the problems of administrative and medical education responsibilities.

It was the general consensus of those attending the meeting that a delay in implementation of this rule would be highly desirable in order to allow adequate time to objectively evaluate and respond to the rule and its compliance with Congressional intent in the Medicare law. The HCFA represenatives, however, offered no commitment for such a delay.

Your Chairman feels the short and long range negative implications of this rule to all physicians, regardless of specialty, give rise to concern for yet more unwarranted and arbitrary governmental regulation of the private practice of medicine.

The motion of the Reference Committee that Resolution 80-13 be adopted as amended carried.

RESOLUTION 80-13
Medicare Reimbursement of Hospital-Based Physicians

RESOLVED, That the Florida Medical Association stands opposed to the implementation of Federal Regulation 42 CFR 405 relating to Medicare reimbursement to hospital-based physicians, and be it further

RESOLVED, That the American Medical Association be urged to adopt this resolution.

Florida Health Data Corporation, Inc.

Since its inception, the Florida Health Data Corporation, Inc., with Dr. James Borland Jr., as President, has continued to collect health data in the State of Florida. The Reference Committee went on record expressing its appreciation for the contributions that the FHDC is producing even in the face of adversity created by its data subcontractors.

The motion of the Reference Committee that the report of the Florida Health Data Corporation, Inc., be adopted carried.

Florida Health Data Corporation, Inc.

James L. Borland Jr., M.D., President

The Florida Health Data Corporation continues to strive to establish and operate an independent health data bank which is accurate, timely, comprehensive and controlled by the private sector. The initial project of this corporation was to establish the Hospital Management and Medical Information System (HMMIS) which is a hospital discharge data abstracting service for the State of Florida.

The progress of the Florida Health Data Corporation was greatly hampered in 1979 by financial problems experienced by FHDC's data subcontractor, Medical Dimensions Incorporated, (MDI) of Houston, Texas. It became necessary in July, 1979, to cancel the contract for data processing with MDI, and the search for a new data subcontractor resulted in the selection of the Professional Insurance Management Company (PIMCO). Due to the lack of cooperation and many other circumstances surrounding the contract with MDI, it became necessary for PIMCO to redesign the entire software package for FHDC's Hospital Management and Medical Informaton System. The remainder of 1979 was devoted to redevelopment of the software and catching up the backlog of processing not completed by MDI.

Delays in providing reports to subscriber hospitals and the selection of a new data processor required staff to make on-site visits to the hospitals. FHDC is appreciative to the FMA for the staff time allocated for this and the general management of FHDC.

As of January, 1980, the HMMIS system is fully operational and marketing efforts have resumed. At the present time, the FHDC has twenty-one subscriber hospitals in Florida and has received inquiries from several hospitals including one from out of state.

Other health data areas have also been addressed such as emergency medical services. As FHDC continues to grow, expansion into other health data areas will occur.

Florida Medical Foundation, PMUR

The Reference Committee read with great interest the information contained in the report from the Florida Medical Foundation regarding Peer Medical Utilization Review. The Reference Committee took the opportunity to commend the Committee on PMUR for its work and efforts on behalf of the physicians of Florida and their patients.

The motion of the Reference Committee that the item on PMUR in the Report of the Florida Medical Foundation be adopted carried. (See Report of the Florida Medical Foundation, page 685).

RESOLUTION 80-14
FMA State Health Plan

Charles F. Tate Jr., M.D., Delegate

The Reference Committee heard considerable commentary with regard to the need for the state health plan to be monitored by and influenced by organized medicine and that there is great concern for documents written by health planners without adequate and appropriate input by Florida physicians. It was recognized that physicians of Florida need to continue to promote the health of the citizens of Florida without government directives in health plans. However, there is considerable concern as to how implementation of a FMA State Health Plan would affect its budgetary requirements. The Reference Committee recognizes that any action of the House that requires alteration of the budget needs Finance and Executive Committee and Board of Governors approval. For this reason, the Reference Committee recommended that Resolution be referred to the Board of Governors.

The motion of the Reference Committee that Resolution 80-14 be referred to the Board of Governors for consideration by the Council on Specialty Medicine and the Committee on HSA's carried.

RESOLUTION 80-14
FMA State Health Plan
[Not Adopted — Referred to the Board of Governors]

Whereas, Each year a State Health Plan is being published by the Health Systems Agencies of the state that will become widely available to all interested parties regarding health matters, and

Whereas, These documents will be referred to for various purposes, not the least of which is legislative and bureaucratic planning and action, and

Whereas, Organized medicine needs to have a constant and continuing forum, and carefully considered statements of its thinking and expertise in this area, in **front** of the same legislative and bureaucratic agencies for study and planning purposes at all times, and

Whereas, the specialty societies of the FMA, with their expertise can easily develop statements and plans reflecting organized medicine's thoughts, at very little cost to FMA; be it therefore

RESOLVED, That each year the Florida Medical Association through its specialty societies and expertise will develop a State Health Plan of its own, for all agencies throughout the state to have immediately available for reference, study and planning purposes.

RESOLUTION 80-9
Medicare — Physicians' Fees

Pinellas County Medical Society

The Reference Committee listened with great interest to the commentary concerning Resolution 80-9. It was noted during the discussion that since May 5, 1980, steps have been taken by Blue Shield of Florida to eliminate the phrase "reduced charge" where it occurs in

Explanation of Medicare Benefits and further, that more appropriate language will be incorporated in these areas. The Reference Committee noted that there are two carriers in Florida and addresses this to these two carriers and therefore offered a substitution for the RESOLVED portion of Resolution 80-9.

The motion of the Reference Committee that Resolution 80-9 be adopted as amended carried.

RESOLUTION 80-9
Medicare — Physicians' Fees

RESOLVED, That the Board of Governors of the Florida Medical Association use whatever means necessary to induce Medicare carriers in Florida to cease telling Medicare recipients that a physician's charge or fee has been reduced and that the FMA work with the carriers to improve the language of communication to Medicare recipients.

RESOLUTION 80-11
Veterans Administration Outpatient Care
Brevard County Medical Society

Testimony was presented to the Reference Committee that the Veterans Administration has recently deleted certain benefits for care of outpatients. There is concern that this policy will lead toward increased cost of care and inefficient delivery of health care.

The motion of the Reference Committee that Resolution 80-11 be adopted as amended carried.

RESOLUTION 80-11
Veterans Administration Outpatient Care

RESOLVED, That the Veterans Administration authorize at its expense, outpatient surgery by the physician of the veteran's choice in the area of his residence.

The Reference Committee expressed appreciation to all those who appeared to provide information and opinions which form the basis of this report.

They expressed their appreciation to the members of the Committee and to Dr. Rufus K. Broadaway, AMA Delegate for their attentiveness and support.

The Reference Committee expressed appreciation to Mr. John Richardson, FMA staff, and Marcia Protheroe for their participation in preparing the report.

The motion of the Reference Committee that the Report of Reference Committee No. V be adopted as amended carried.

Elections
President-Elect

The Speaker opened the floor for nominations for the office of President-Elect of the Association for 1980-81.



Having just been promoted by the House of Delegates from Speaker of the House to President-Elect, Sanford A. Mullen, M.D., Jacksonville (left), turned the gavel over to James B. Perry, M.D., Fort Lauderdale, who moved up from Vice Speaker to Speaker.

Dr. Yank Coble, of Duval County, placed in nomination the name of Dr. Sanford A. Mullen of Jacksonville.

Dr. Mullen's nomination was seconded by Dr. Warren Lindeau of Dade County; Dr. Irving Essrig of Hillsborough County; Dr. Barney McRae of Columbia County; Dr. Arthur Eberly of Broward County; Dr. Franklin Pfeiffenberger of Sarasota County; and Dr. Roy Campbell of Putnam County.

Dr. Eugene Valentine of Okaloosa County placed in nomination the name of Dr. William W. Thompson of Fort Walton Beach.

Dr. Thompson's nomination was seconded by Dr.

James Winslow of Hillsborough County; Dr. Charles Kahn of Escambia County; Dr. Thomas Regan of Broward County; and Dr. David Overbey of Pinellas County.

Nominations were closed. Dr. Sanford A. Mullen, of Jacksonville, was elected President-Elect.

Dr. William W. Thompson moved that the House of Delegates give its unanimous support to Dr. Mullen. The motion carried.

Vice President
Secretary
Treasurer
Speaker of the House

The floor was opened for nominations for the office of Vice President. Dr. Bill Hartley of Broward County moved that all of the names of the announced, unopposed candidates for Vice President, Speaker of the House, Secretary and Treasurer and AMA Delegates and Alternates (Seats No. 3 and 5) be placed in nomination and that the nominations be closed. The motion carried. All nominees to the stated offices were elected by unanimous vote of the House and are:

Vice President — Gerold L. Schiebler, M.D.
Speaker of the House — James B. Perry Jr., M.D.
Secretary — Robert E. Windom, M.D.
Treasurer — J. Russell Forlaw, M.D.

AMA Delegates and Alternates
Terms 1-1-81 — 12-31-82

Seat #3 — Delegate — Charles K. Donegan, M.D.
Alternate — Francis C. Coleman, M.D.
Seat #5 — Delegate — Richard G. Connar, M.D.
Alternate — Vernon B. Astler, M.D.
Seat #2 — Delegate — Samuel M. Day, M.D.

Vice Speaker of the House

The Speaker opened the floor for nominations for the office of Vice Speaker of the House of Delegates for 1980-81.

Dr. Clarence Gilbert of Orange County placed in nomination the name of Dr. Franklin B. McKechnie of Winter Park.

Dr. McKechnie's nomination was seconded by Dr. John Petrakis of Hillsborough County.

Dr. David Sims of Dade County placed in nomination the name of Dr. Banning G. Lary of Miami.

Dr. Lary's nomination was seconded by Dr. John S. Hagen of Lee County; Dr. John Fletcher of Hillsborough County; Dr. William Davenport of Dade County; and Dr. Richard Dever of Duval County.

Nominations were closed. Dr. Franklin B. McKechnie was elected Vice Speaker of the House of Delegates.

AMA Alternate Delegate — Seat No. 2

The Speaker opened the floor for nominations for the AMA Alternate Delegate for Seat No. 2.

Dr. Jack Q. Cleveland of Dade County withdrew his name from the nomination and nominated Dr. Charles F. Tate of Miami.

Dr. Tate's nomination was seconded by Dr. Howard DeBose of Polk County; Dr. Thomas McKell of Hillsborough County; Dr. Walter Jarrell of Duval County; Dr. Alvin E. Smith of Volusia County; Dr. Philip Cotton of Bay County; and Dr. Fred Carten from Martin County.

Dr. Frederick Weigand of Seminole County placed in nomination the name of Dr. Luis M. Perez of Sanford.

Dr. Perez's nomination was seconded by Dr. Doris Carson of Duval County; Dr. Jim Richards of Orange County; Dr. Charles Kahn of Escambia County; Dr. Luis Guerrero of Palm Beach County; Dr. Ronald Seeley of Hillsborough County and Dr. John Hamilton of Pinellas



Gerold L. Schiebler, M.D., Gainesville, former Editor of *The Journal*, is escorted to the podium to accept election as FMA Vice President. Escorts are: O. Frank Agee, M.D. (left), and William B. Deal, M.D., both of Gainesville.

Nominations were closed. Dr. Luis M. Perez of Sanford was elected AMA Alternate Delegate for Seat No. 2.

Dr. Charles F. Tate moved that the House of Delegates give its unanimous support to Dr. Perez. The motion carried.

Dr. Broadaway of Dade County addressed the House. Dr. Broadaway noted the House was seeing stepping down from a national position a legend in Jack Cleveland. He stated that the entire Association was very proud of Dr. Cleveland. Dr. Cleveland had been a great soldier in the ranks and a great leader. From time to time he has been plagued with problems that would have caused many to step down long before. He has been faithful, he has been attentive and true to our cause. Dr. Broadaway stated the Dade County delegation would keep Dr. Cleveland as a delegate because they loved him.

Dr. Jack Q. Cleveland was given a standing ovation from the House of Delegates.

Judicial Council

The Speaker referred the House to the report of the Board of Governors in which the Board had nominated Dr. O. Frank Agee for election from District A for a five-year term expiring in 1985, to the Judicial Council.

The nomination was adopted and Dr. O. Frank Agee was elected.

Committee on Membership and Discipline

The Speaker referred the House to the nominations for election to the Committee on Membership and Discipline as submitted by the Board of Governors in its report and asked for additional nominations from the floor. There being no nominations from the floor, it was moved and seconded that the nominees as proposed by the Board of Governors be elected to the Committee on Membership and Discipline. The motion carried.

District 1	Robert Palmer, M.D. (84)
District 2	James T. Cook Jr., M.D. (84)
District 3	John A. Rush, M.D. (84)
District 4	Richard W. Snodgrass, M.D. (84)
District 5	Frederick C. Andrews, M.D. (84)
District 6	John T. Karaphillis, M.D. (84)
District 7	William B. Hopkins, M.D. (84)
District 8	Wiley E. Koon, M.D. (84)
District 9	Clarence M. Gilbert, M.D. (84)
District 10	Douglas R. Murphy, M.D., (84)
District 11	Ray E. Murphy, M.D. (84)
District 12	Anthony J. Vento, M.D. (84)
	John I. Williams, M.D. (83)
District 13	Arthur W. Wood Jr., M.D. (84)
District 14	Rufus K. Broadaway, M.D. (84)
District 15	Norman M. Kenyon, M.D. (84)

President Thames announced the presidential appointments to the Board of Governors.

District D — Norman M. Kenyon, M.D.
At Large Member — James F. Richards, M.D.
AMA Representative — Joseph C. Von Thron, M.D.
Exec. Committee Appointment — J. Lee Dockery, M.D.

The Speaker resumed the Chair and called on Dr. William Davenport for the benediction.

Dr. Davenport: "Almighty God, on this beautiful Mother's Day in Florida, we pray for your blessings on this group of physicians as we return to our homes. May our accomplishments at this meeting result in better health care for the people of Florida. We are thankful that most of our disagreements are resolved at these meetings and that we can and must function in unity for the coming year."

The 1980 House of Delegates adjourned at 11:00 a.m.

Blues Consolidate to Form New Corporation

Florida Blue Shield and Florida Blue Cross are in the process of consolidating to form a new corporation — Blue Cross and Blue Shield of Florida, Inc. The boards of the two corporations approved the consolidation on March 21, 1980, to become effective upon completion of necessary business and legal steps.

The consolidation is a result of a 10-month study of the Plans' operations, programs and policies, and is an effort to better meet the needs of Florida physicians, citizens and hospitals. The reorganization will also allow the corporation greater financial flexibility and permit funding of innovative programs to benefit physicians, hospitals and the public, Blue Cross and Blue Shield explained.

The consolidation, which has existed in the public perception for a number of years, will not effect current physician participation agreements. The initial active membership will be the current combined boards of the Blue Cross and Blue Shield Plans, and the first 31-member board of the new corporation will be established from membership of the current boards.

FMA AUXILIARY

Auxilians Active in Legislation

Through FMA leadership, the Auxiliary has become extremely active in the Florida Medical Association's legislative program.

One of the Auxiliary's most important contributions has been in the area of communication. Each county has been requested to establish a Legislative Alert System (LegsAlert). This communication network has the potential for playing a most vital role in our legislative efforts. Basically, the network is a pyramid-type communication system. Each county auxiliary legislation chairman is responsible for activating the LegsAlert in her area when she receives direction from the FMA. There must be enough members on the LegsAlert committee to contact immediately the physicians and auxiliary members who have indicated their willingness to respond as needed — either contact their legislators by letter (if time), telegram or telephone, or go to Tallahassee. Each county legislation chairman has information about the bill, the suggested action that should be taken, and the contact to be made. She then will start her telephone chain. Essential to this system's success is timing — the LegsAlert calls for immediate action.

Additionally, the Legislative Conference in Tallahassee during the 1980 Session expanded this past year to include active physician participation. Many key contact physicians and legislative committee chairmen attended the two-day meeting. The program included speakers, FMA staff, observance of the House and Senate in Session, monitoring House and Senate committees, meeting with legislators, and a legislative and political education workshop.

This joint effort of the FMA and Auxiliary also is working at the county level, with most county medical societies including auxiliary members on their candidate selection committee and legislative committee.

Through continued cooperation between the FMA and Auxiliary, we can become aware of how state and federal legislation affects us all, we can keep informed on current bills and issues, we can learn how to give responsible input to our legislators, and we can provide others with a more objective view of state and national issues.

The development of strong personal relationships between local physicians, auxiliary members and legislators throughout the state has been and will continue to be the basis for success during the coming years, and we must pursue this endeavor.

Mrs. James G. White (Beebe)
State Legislation Chairman

Cooperative Familial Aneurysm Registry

A center for the registration of families in which several members have proven saccular aneurysms is being established at St. Vincent's Medical Center in Jacksonville, Florida. It is the purpose of this registry to accumulate sufficient medical data to establish the possible role of heredity in the development of saccular aneurysms. If you have families in which two or more members have angiographically, surgically or autopsy-proven saccular intracranial aneurysms, please write or call:

Gaston J. Acosta-Rua, M.D., Registrar Director
Cooperative Familial Aneurysm Registry
St. Vincent's Medical Center
P.O. Box 2982
Jacksonville, Florida 32203

Fourteenth Annual Benefit Art Show Winners 1979 - 1980

ADULT DIVISION

Best in Show — Constance Amundson (Mrs. I. M. Essrig) Tampa, Pencil Drawing "Distortion of Memory by Time"

Painting Division

1st Place — "Magi" (Mrs. James D. Moody) Orlando, Oil Painting "Vespers"

2nd Place — Dr. Robert E. Pickard, Coral Gables, Watercolor-Ink, "Captiva Idyllic"

Merit Awards — Catie (Mrs. Thomas D. Cook) Orlando, Oil Painting "Snowfall"
Phyllis Keenan, Leesburg, Pastel, "For Allan, With Love, Mom"

Graphics

1st Place — Constance Amundson (Mrs. I. M. Essrig) Tampa, Pencil Drawing, "Distortion of Memory by Time"

2nd Place — Dorothy Foley, Brevard, Photography, "Palace of Fine Arts"

Merit Awards — Dr. Joseph Matthews, Orlando, Photography, "Happy Baby"
Frannie Matthews, Orlando, Photography, "Spring in Colorado"

Crafts

1st Place — Dr. Robert Pickard, Coral Gables, Sculpture, Mahogany "Seated Woman"

2nd Place — Dr. Judd Bockner, Boca Raton, Sculpture, Alabaster, "Sails"

Merit Awards — Mrs. John E. Startzman, Orlando, Sterling Silver Jewelry
Janice (Mrs. Bradley M. Rodgers) Gainesville, Sculputure, Child's Head

YOUTH DIVISION

Best in Show — Ginger Bowman, Age 11, Tequesta, Watercolor, "Spring's Arrival"

Painting Division

1st Place — Ginger Bowman, Age 11, Tequesta, Watercolor, "Spring's Arrival"

2nd Place — Kathy Tignor, Age 13, North Palm Beach, Oil, "Home in the Smokies"

Merit Awards — Mary Money Roberson, Age 12, Ormond Beach, Acrylic Painting
Elizabeth Rodgers, Age 9, Gainesville, Painting, Tiger
Courtney Hollis, Age 12, Ormond Beach, Acrylic Painting, "Seascape"

Graphics

1st Place — John Tignor, Age 16, North Palm Beach, Photography "Cooling Off"

2nd Place — Robbie Miller, Age 5½, Lighthouse Point, Woodcut "My Panda"

Merit Award — Sally Ann Ramiriz, Age 16, Miami, Photographic Color Key "Backyard Fantasy"

Crafts

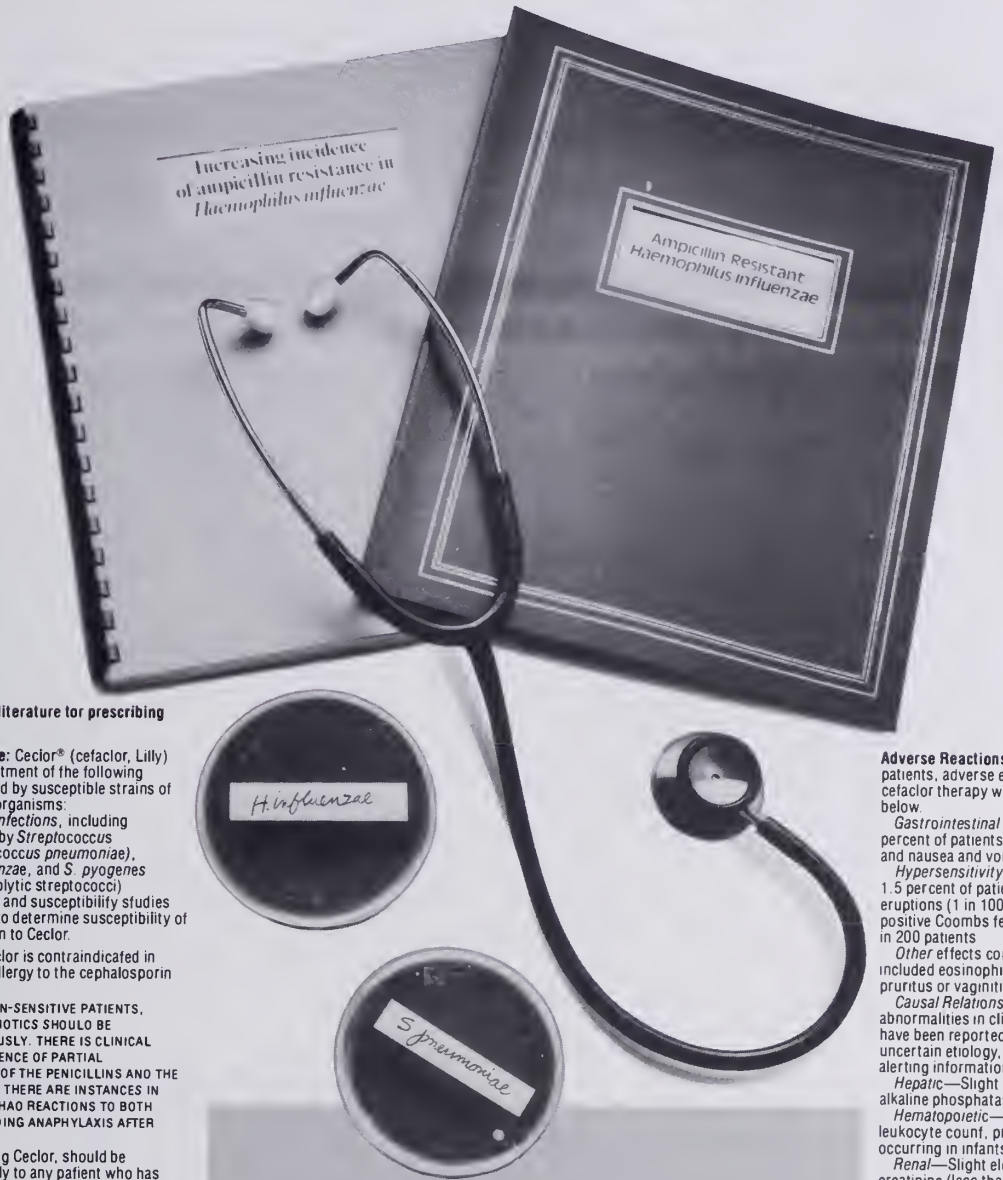
2nd Place — Margery Susan Gordan, Age 7, Miami Lakes, Plaster Relief "Playtime"

*There were not enough entries in this category for more awards.

EDITOR'S AWARD — Dr. James D. Moody, Orlando, Oil Painting, "Star Orchids"

Judge — Professor Leon Willig — Art Dept. University of Miami
Chairman — Mrs. Carlos G. Llanes (Martha)

An added complication... in the treatment of bacterial bronchitis*



Brief Summary.
Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae)*, *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER PARENTERAL USE).

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefaclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

Usage in Pregnancy—Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy—Safety of this product for use in infants less than one month of age has not been established.

Adverse Reactions: In clinical studies in 1493 patients, adverse effects considered related to cefaclor therapy were uncommon and are listed below.

Gastrointestinal symptoms occurred in about 2.5 percent of patients and included diarrhea (1 in 70) and nausea and vomiting (1 in 90).

Hypersensitivity reactions were reported in about 1.5 percent of patients and included morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs tests each occurred in less than 1 in 200 patients.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory tests results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200). [070379R]

Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

Ceclor®
cefaclor
Pulvules®, 250 and 500 mg

* Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.[8]

Note: Ceclor® (cefaclor) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

References

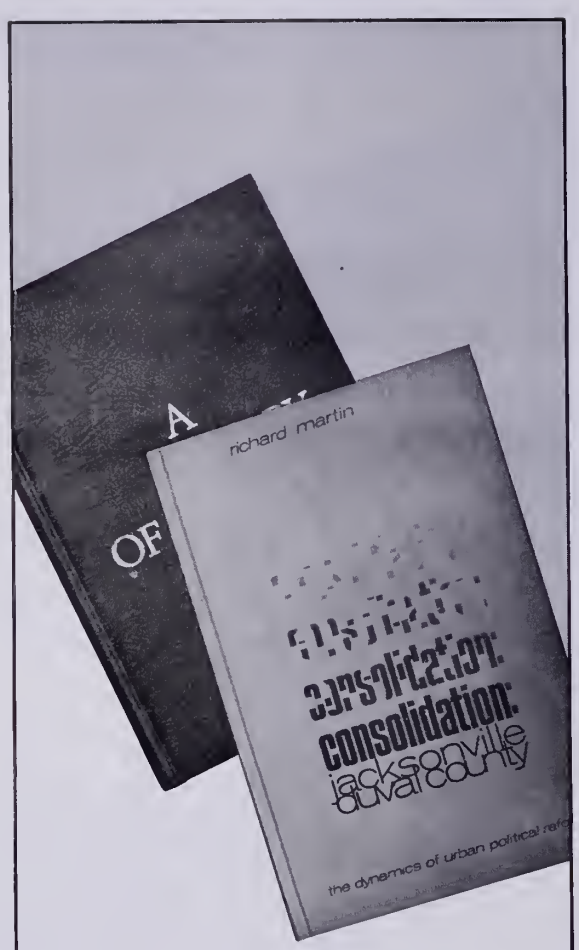
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5. Current Chemotherapy (edited by W. Siegenthaler and R. Luthy), II: 880. Washington, D.C.: American Society for Microbiology, 1978.
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7. Data on file, Eli Lilly and Company.
8. Principles and Practice of Infectious Diseases (edited by G. L. Mandell, R. G. Douglas, Jr., and J. E. Benneff), p. 487. New York: John Wiley & Sons, 1979.

Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285

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Quinamm™

AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

INDICATIONS: For the prevention and treatment of nocturnal recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis, and static foot deformities.

CONTRAINDICATIONS: Because of the quinine content, Quinamm is contraindicated in women of childbearing potential, in pregnancy, in patients with known quinine sensitivity, and in patients with glucose-6-phosphate dehydrogenase deficiency. Hemolysis (with the potential for hemolytic anemia) has been associated with a G-6-PD deficiency in patients taking quinine.

PRECAUTIONS: Thrombocytopenic purpura may follow the administration of quinine in highly sensitive patients. Recovery will follow withdrawal of the medication.
Cinchona alkaloids, including quinine, have the potential to depress the hepatic enzyme system that synthesizes the vitamin K-dependent factors. The resulting hypoprothrombinemic effect may enhance the action of warfarin and other oral anticoagulants.

ADVERSE REACTIONS: Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. If ringing in the ears, deafness, skin rash, or visual disturbances occur, the drug should be discontinued.

DOSAGE AND ADMINISTRATION:
1 tablet upon retiring. When necessary, 1 additional tablet may be taken following the evening meal.

Product Information as of September, 1977

U.S. Patent 2,985,558

Merrell

MERRELL-NATIONAL LABORATORIES Inc.
Cayey, Puerto Rico 00633

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8 3305 (Y371A)

for Knotts in the night



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each tablet contains quinine sulfate 260 mg., aminophylline 195 mg.

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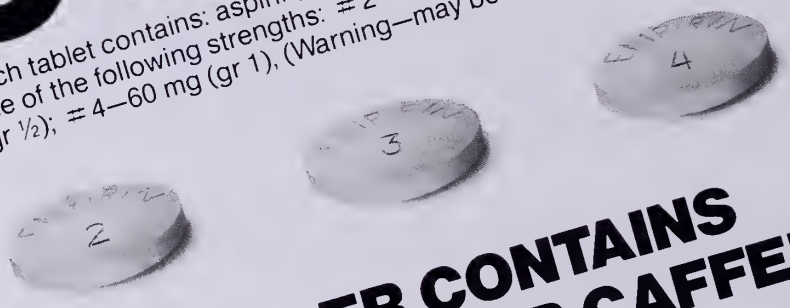
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Each tablet contains: aspirin, 325 mg; plus codeine phosphate in one of the following strengths: #2—15 mg (gr ¼); #3—30 mg (gr ½); #4—60 mg (gr 1), (Warning—may be habit-forming)



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A non-narcotic one-two punch against pain, with concurrent relief of anxiety/tension

EQUAGESIC®

meprobamate and ethoheptazine citrate with aspirin) Wyeth

UAGESIC—Abbreviated Summary

INDICATIONS: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:
"Possibly" effective for the treatment of pain accompanied by tension and/or anxiety in patients with musculoskeletal disease or tension headache.
Final classification of the less-than-effective indications requires further investigation.
The effectiveness of Equagesic in long-term use, i.e more than four months, has not been assessed by systematic clinical studies. The physician should periodically reassess usefulness of the drug for the individual patient.

NTRAINDICATIONS: Equagesic should not be given to viduals with a history of sensitivity or severe intolerance spirin, meprobamate, or ethoheptazine citrate

RNINGS: Careful supervision of dose and amounts prebed for patients is advised, especially with those patients known propensity for taking excessive quantities of drugs. essive and prolonged use in susceptible persons, e g , holics, former addicts, and other severe psychoneurot- has been reported to result in dependence on or habiton to the drug Where excessive dosage has continued weeks or months, dosage should be reduced gradually er than abruptly stopped, since withdrawal of a "crutch" precipitate withdrawal reaction of greater proportions that for which the drug was originally prescribed Abrupt ontinuance of doses in excess of the recommended dose resulted in some cases in the occurrence of epileptiform ures
cial care should be taken to warn patients taking meprobate that tolerance to alcohol may be lowered with reant slowing of reaction time and impairment of judgement coordination

AGE IN PREGNANCY AND LACTATION: An increased risk of congenital malformations associated with use of minor tranquilizers (meprobamate, chlordiazepoxide, and diazepam) during the first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of child-bearing potential may be pregnant at the time of institution of therapy should be considered. Patients should be advised that if they become pregnant during therapy or intend to become pregnant they should communicate with their physicians about the desirability of discontinuing the drug.

Meprobamate passes the placental barrier. It is present both in umbilical-cord blood at or near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breast-feeding patients, the drug's higher concentrations in breast milk as compared to maternel plesma levels should be considered.

Preparations containing aspirin should be kept out of the reach of children Equagesic is not recommended for patients 12 years of age and under

PRECAUTIONS: Should drowsiness, ataxia, or visual disturbance occur, the dose should be reduced If symptoms continue, patients should not operate a motor vehicle or any dangerous machinery

Suicidal attempts with meprobamate have resulted in coma, shock, vasomotor and respiratory collapse, and anuria Very few suicidal attempts were fatal, although some patients ingested very large amounts of the drug (20 to 40 gm). These doses are much greater than recommended. The drug should be given cautiously, and in small amounts, to patients who have suicidal tendencies. In cases where excessive doses have been taken, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels Hyperventilation has been reported occasionally Any drug remaining in the stomach should be removed and symptomatic treatment given Should respiration become very shallow and slow, CNS stimulants, e g , caffeine, Metrazol, or amphetamine, may be cautiously administered If severe hypotension develops, pressor amines should be used parenterally to restore blood pressure to normal levels.

ADVERSE REACTIONS: A small percentage of patients may experience nausea with or without vomiting and epigastric distress Dizziness occurs rarely when meprobamate and ethoheptazine citrate with aspirin is administered in recommended dosage The meprobamate may cause drowsiness but, as a rule, this disappears as therapy is continued Should drowsiness persist and be associated with ataxia, this symptom can usually be controlled by decreasing the dose, but occasionally it may be desirable to administer central stimulants such as amphetamine or mephentermine sulfate concomitantly to control drowsiness

A clearly related side effect to the administration of meprobamate is the rare occurrence of allergic or idiosyncratic reactions This response develops, as a rule, in patients who have had only 1-4 doses of meprobamate and have not had a previous contact with the drug Previous history of allergy may or may not be related to the incidence of reactions.

Mild reactions are characterized by an itchy urticarial or erythematous, maculopapular rash which may be generalized or confined to the groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema, and fever have also been reported

More severe cases, observed only very rarely, may also have other allergic responses, including fever, fainting spells, angioneurotic edema bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case), and hyperthermia Treatment should be symptomatic such as administration of epinephrine, antihistamine, and possibly hydrocortisone Meprobamate should be stopped, and reinstitution of therapy should not be attempted

Rare cases have been reported where patients receiving meprobamate suffered from aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia In nearly every instance reported, other toxic agents known to have caused these conditions have been associated with meprobamate A few ceses of leukopenia during continuous administration of meprobamate are reported, most of these returned to normal without discontinuation of the drug

Impairment of accommodation and visual acuity has been reported rarely

OVERDOSE: Two instances of accidental or intentional significant overdosage with ethoheptazine citrate combined with aspirin have been reported These were accompanied by symptoms of CNS depression, including drowsiness and light-headedness, with uneventful recovery However, on the basis of pharmacological data, it may be anticipated that CNS stimulation could occur Other anticipated symptoms would include nausea and vomiting Appropriate therapy of signs and symptoms as they appear is the only recommendation possible at this time Overdosage with ethoheptazine combined with aspirin would probably produce the usual symptoms and signs of salicylate intoxication. Observation and treatment should include induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions

DESCRIPTION: Each Equagesic tablet contains 150 mg meprobamate, 75 mg ethoheptazine citrate and 250 mg aspirin.

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*This drug has been evaluated as possibly effective for this indication.

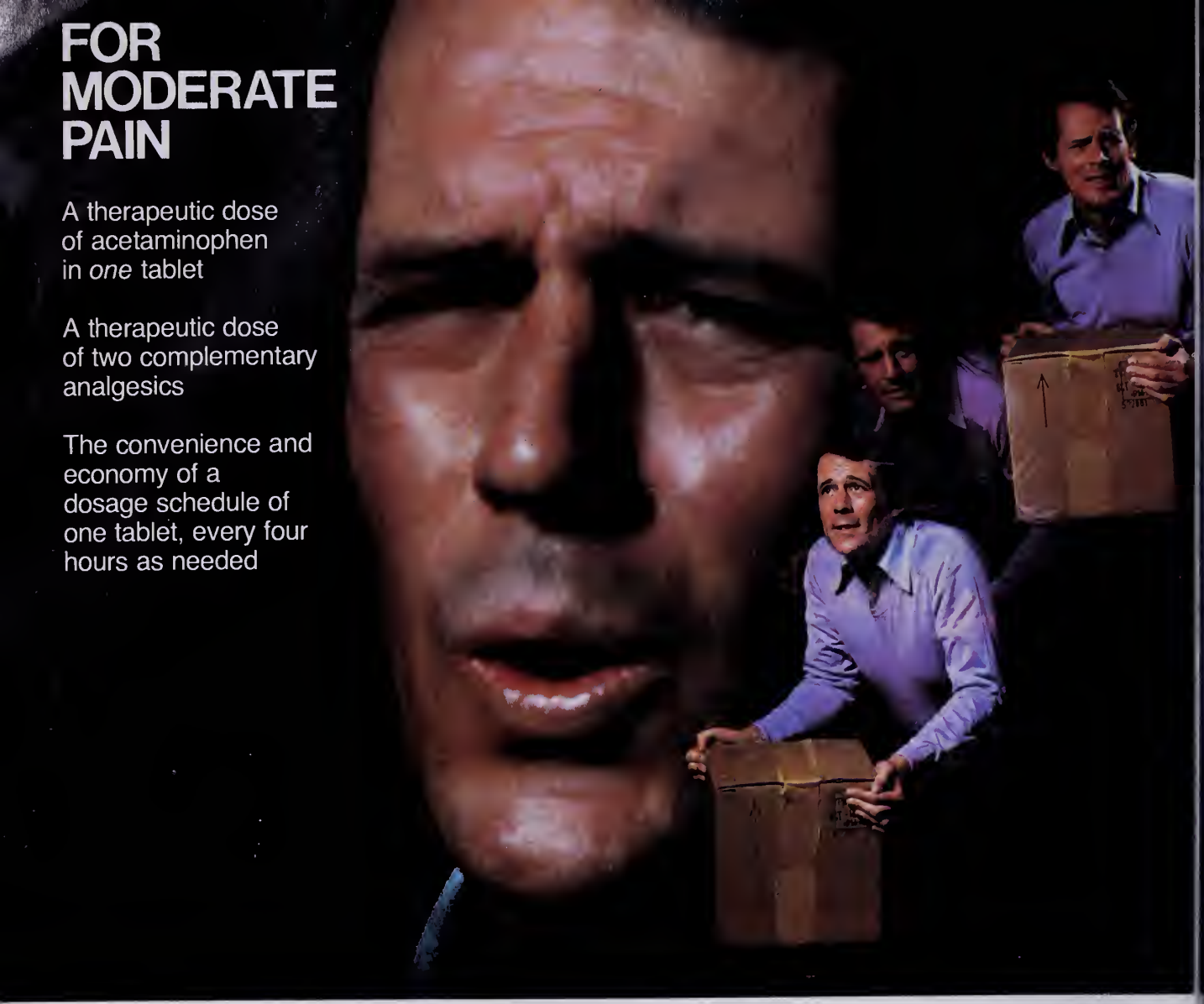
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FOR MODERATE PAIN

A therapeutic dose of acetaminophen in *one* tablet

A therapeutic dose of two complementary analgesics

The convenience and economy of a dosage schedule of one tablet, every four hours as needed



WHY NOT WYGESIC® C IV

(65 mg propoxyphene HCl and 650 mg acetaminophen) Wyeth

WYGESIC—Abbreviated Summary

INDICATION: For the relief of mild-to-moderate pain.

CONTRAINDICATION: Hypersensitivity to propoxyphene or to acetaminophen.

WARNINGS: CNS ADDITIVE EFFECTS AND OVERDOSAGE. Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, or other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. Toxic effects and fatalities have occurred following overdoses of propoxyphene alone or in combination with other CNS depressants. Most of these patients had histories of emotional disturbances or suicidal ideation or attempts, as well as misuse of tranquilizers, alcohol, or other CNS-active drugs. Caution should be exercised in prescribing large amounts of propoxyphene for such patients (see **Management of Overdosage**).

DRUG DEPENDENCE: Propoxyphene can produce drug dependence characterized by psychic dependence and less frequently, physical dependence and tolerance. It will only partially suppress the withdrawal syndrome in individuals physically dependent on morphine or other narcotics. The abuse liability of propoxyphene is qualitatively similar to codeine's although quantitatively less, and propoxyphene should be prescribed with the same degree of caution appropriate to the use of codeine.

USAGE IN AMBULATORY PATIENTS: Propoxyphene may impair the mental and/or physical abilities required for potentially hazardous tasks, e.g. driving a car or operating machinery. Patients should be cautioned accordingly.

USAGE IN PREGNANCY: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. INSTANCES OF WITHDRAWAL SYMPTOMS IN THE NEONATE HAVE BEEN REPORTED FOLLOWING USAGE DURING PREGNANCY. Therefore, propoxyphene should not be used in pregnant women unless, in the judgement of the physician, the potential benefits outweigh the possible hazards.

USAGE IN CHILDREN: Propoxyphene is not recommended for children because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric group.

PRECAUTIONS: Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine. The CNS depressant effect of propoxyphene may be additive with other CNS depressants, including alcohol.

ADVERSE REACTIONS: The most frequent adverse reactions are dizziness, sedation, nausea, and vomiting. These seem more prominent in ambulatory than in nonambulatory patients; some of these reactions may be alleviated if the patient lies down.

Other adverse reactions include constipation, abdominal pain, skin rashes, light-headedness, headache, weakness, euphoria, dysphoria, and minor visual disturbances. The chronic ingestion of propoxyphene in doses over 800 mg per day has caused toxic psychoses and convulsions. Cases of liver dysfunction have been reported.

DRUG INTERACTIONS: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, and other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. (see **Warnings**) Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine.

MANAGEMENT OF OVERDOSAGE: SYMPTOMS. The manifestations of serious overdosage with propoxyphene are similar to those of narcotic overdosage and include respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, pupillary constriction, and circulatory collapse. In addition to these characteristics, which are reversed by narcotic antagonists such as naloxone, there may be other effects. Overdoses of propoxyphene can cause delay of cardiac conduction as well as focal or generalized convulsions, a prominent feature in most cases of severe poisoning. Cardiac arrhythmias and pulmonary edema have occasionally been reported, and apnea, cardiac arrest, and death have occurred.

Symptoms of massive overdosage with acetaminophen may include nausea, vomiting, anorexia, and abdominal pain, beginning shortly after ingestion and lasting for 12 to 24 hours. However, early recognition may be difficult since early symptoms may be mild and nonspecific. Evidence of liver damage is usually delayed. After the initial symptoms, the patient may feel less ill; however, laboratory determinations are likely to show a rapid rise in liver enzymes and bilirubin. In case of serious hepatotoxicity, jaundice, coagulation defects, hypoglycemia, encephalopathy, coma, and death may follow. Renal failure due to tubular necrosis, and myocardiopathy, have also been reported.

Ingestion of 10 grams or more of acetaminophen may produce hepatotoxicity. A 13-gram dose has reportedly been fatal.

TREATMENT: Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation. The narcotic antagonists, naloxone, nalorphine, and levallorphan, are specific antidotes against the respiratory depression produced by propoxyphene. An appropriate dose of one of these antagonists should be administered, preferably IV, simultaneously with efforts at respiratory resuscitation and the antagonist should be repeated as necessary until the patient's condition remains satisfactory. In addition to a narcotic antagonist, the patient may require careful titration with an anticonvulsant to control seizures. Analeptic drugs (e.g. caffeine or amphetamine) should not be used because of their tendency to precipitate convulsions.

Oxygen, IV fluids, vasopressors and other suppor tive measures should be used as indicated. Gastric lavage may be helpful. Activated charcoal can ab sorb a significant amount of ingested propoxyphene Dialysis is of little value in poisoning by propoxy phene alone. Acetaminophen is rapidly absorbed and efforts to remove the drug from the body should not be delayed. Copious gastric lavage and/or induction of emesis may be indicated. Activated charcoa is probably ineffective unless administered almos immediately after acetaminophen ingestion. Neithe forced diuresis nor hemodialysis appears to be ef fective in removing acetaminophen. Since acetami nophen in overdose may have an antidiuretic effec and may produce renal damage, administration o fluids should be carefully monitored to avoid over load. It has been reported that mercaptamine (cys teamine) or other thiol compounds may protect agains liver damage if given soon after overdosage (8-1 hours). N-acetylcysteine is under investigation as less toxic alternative to mercaptamine, which ma cause anorexia, nausea, vomiting, and drowsines Appropriate literature should be consulted for furthe information. (JAMA 237:2406-2407, 1977)

Clinical and laboratory evidence of hepatotoxicity ma be delayed up to one week. Acetaminophen plasm levels and half-life may be useful in assessing th likelihood of hepatotoxicity. Serial hepatic enzym determinations are also recommended.

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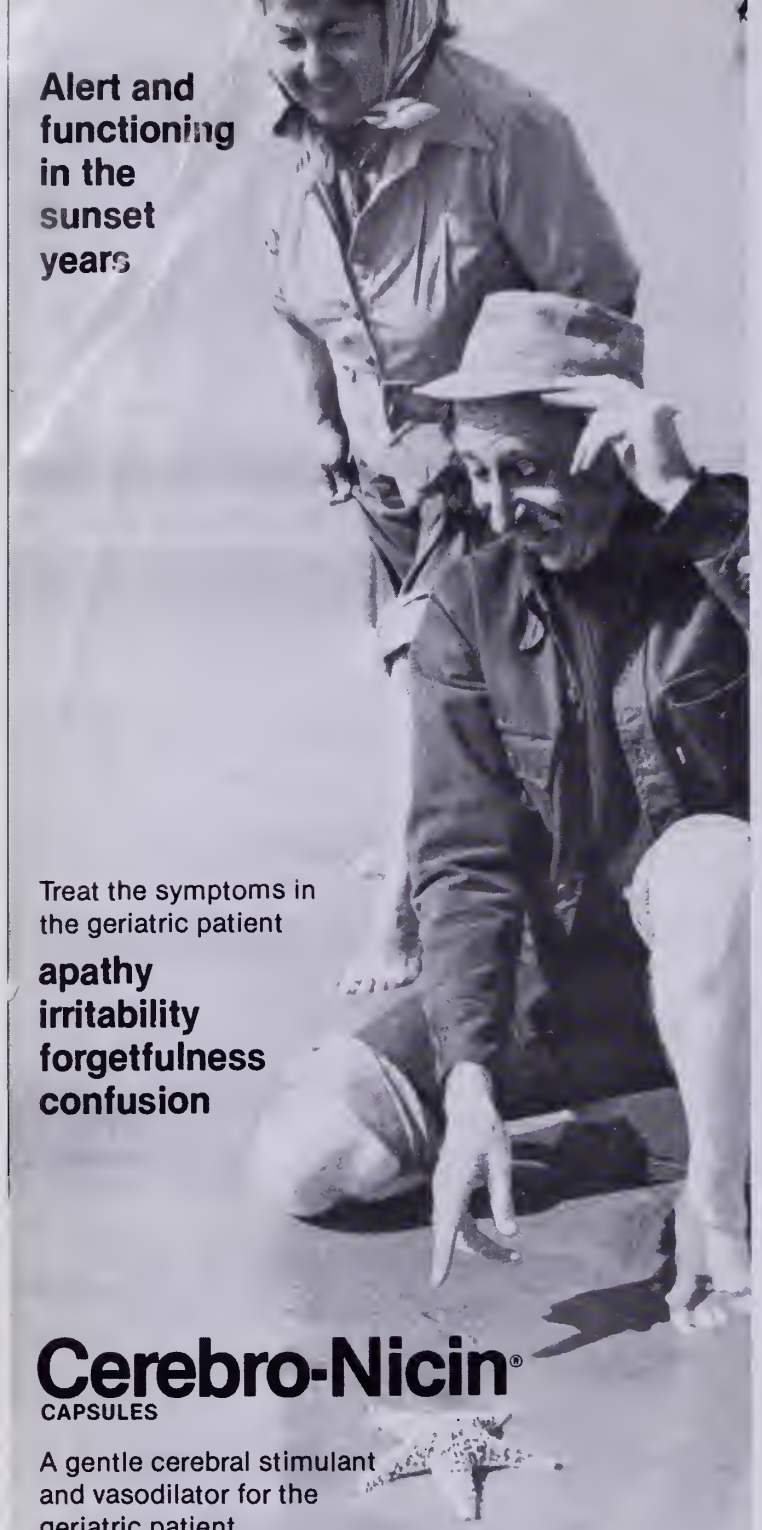
Registration: $600.*

Enrollment must be limited because of extensive faculty/registrant interaction.

For registration and information write to:

Jose S. Bocles, M.D.
Department of Medicine (R760)
University of Miami School of Medicine
P.O. Box 016760, Miami, Florida 33101
Phone: (305) 547-6063

*Includes tuition, set of textbooks, self-assessment questionnaires, use of audio-visual aids, library loan of T.V. tapes, cassette tapes and sets of slides.



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SIDE EFFECTS: Most persons experience a flushing and tingling sensation after taking a higher potency nicotinic acid. As a secondary reaction some will complain of nausea, sweating and abdominal cramps. The reaction is usually transient.

INDICATIONS: As a cerebral stimulant and vasodilator.

RECOMMENDED GERIATRIC DOSAGE: One capsule three times daily adjusted to the individual patient.

WARNING: Overdosage may cause muscle tremor and convulsions.

CONTRAINDICATIONS: Epilepsy or low convulsive threshold.

CAUTION: Federal law prohibits dispensing without prescription. Keep out of reach of children.

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MEETINGS

Accepted by the FMA Committee on Continuing Medical Education for Mandatory Credit

AUGUST

Fundamental and Clinical Aspects of Internal Medicine, Aug. 1980.*

Basic Life Support (CPR), Aug. 5, University Community Hospital Conference Room, Tampa. For information: John E. Perchalski, M.D., 10320 N. 56th St., Suite G, Temple Terrace 33617.

Recent Advances in Medicine, Aug. 11-12, Orlando Hyatt Hotel, Kissimmee. For information: Emelie H. Ongcapin, M.D., St. Barnabas Medical Center, Dept. of Pathology, Old Short Hills Road, Livingston, New Jersey 07039.

Annual Florida Registry Workshop, Aug. 13-15, Holiday Inn Surfside, Daytona Beach. For information: John Carbonneau, 1001 South Macdill Avenue, Tampa 33609.

EKG Interpretation and Arrhythmia Management, Aug. 22-23, Dutch Inn, Lake Buena Vista. For information: International Medical Education Corp., Division of Postgraduate Education, Dept. 12, 64 Inverness Dr., E., Englewood, Colorado 80112.

Third Annual "Innovations in Medical Care", Aug. 23-24, Sandestin Resort, Sandestin. For information: Sandra Knight, 812 W. 11th St., Suite C, Panama City 32401.

18th Annual Seminar in Cardiology, Aug. 30-Sept. 6, Copenhagen, Denmark. For information: Henry J. L. Marriott, M.D., Rogers Heart Foundation. St. Anthony's Hospital, St. Petersburg 33705.

SEPTEMBER

Sixth Cardiovascular Symposium, Sept. 4-5, Gainesville Hilton, Gainesville. For information: Howard W. Ramsey, M.D., 1131 N.W. 64th Terrace, Gainesville 32605.

Dermatology in Florida, Sept. 8, Citrus Memorial Hospital, Inverness. For information: R. Edward Dodge Jr., M.D., 511 W. Highland Blvd., Inverness 32650.

Neurology for Neurologists, Sept. 25-27, Palm Beach. For information: Stephen A. Shaivitz, M.D., 3701 Broadway, West Palm Beach 33407.

OCTOBER

Echocardiography In-Service Workshop, Oct. 20-24, University of Miami, Jackson Memorial Medical Center, Miami.*

21st Workshop in EKG for Nurses and Physicians, Oct. 30-Nov. 3, Sheraton Sand Key Hotel, Clearwater Beach. For information: Henry J. L. Mariott, M.D., St. Anthony's Hospital, St. Petersburg 33705.

NOVEMBER

Fourth Annual Suncoast Perinatal Conference, Nov. 7-8, Bayfront Medical Center, St. Petersburg. For information: Mrs. Pat Fowler, Bayfront Medical Center, 701 Sixth St. S., St. Petersburg 33701.

Vascular Lesion of CNS, Nov. 10, Citrus Memorial Hospital, Inverness. For information: R. Edward Dodge Jr., M.D., 511 W. Highland Blvd., Inverness 32650.

Hypertension Workshop, Nov. 13, Abbey Hospital Conference Room, Coral Gables. For information: Anthony J. Pellicane Sr., M.D., 5190 S.W. 8th St., Coral Gables 33134.

***For information: Contact Division of Continuing Medical Education, D23-3, University of Miami School of Medicine, P.O. Box 016960, Miami 33101. Tel. (305) 547-6716.**

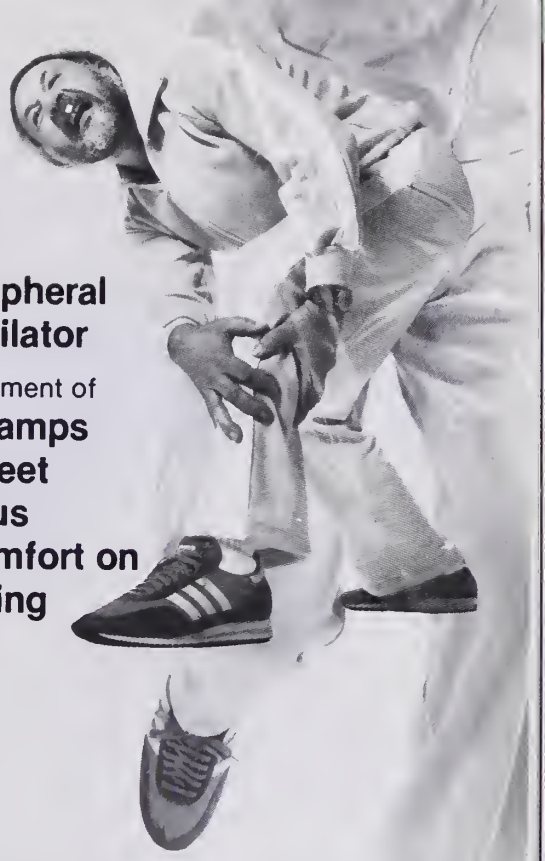
****For information: Contact Division of Continuing Education, Box J-233, J. Hillis Miller Health Center, Gainesville 32610. Tel. (904) 392-3143, or 392-3183.**

+For information: Contact Janifer M. Judisch, M.D., CME, University of South Florida, Tampa 33620. Tel. (813) 974-2196.

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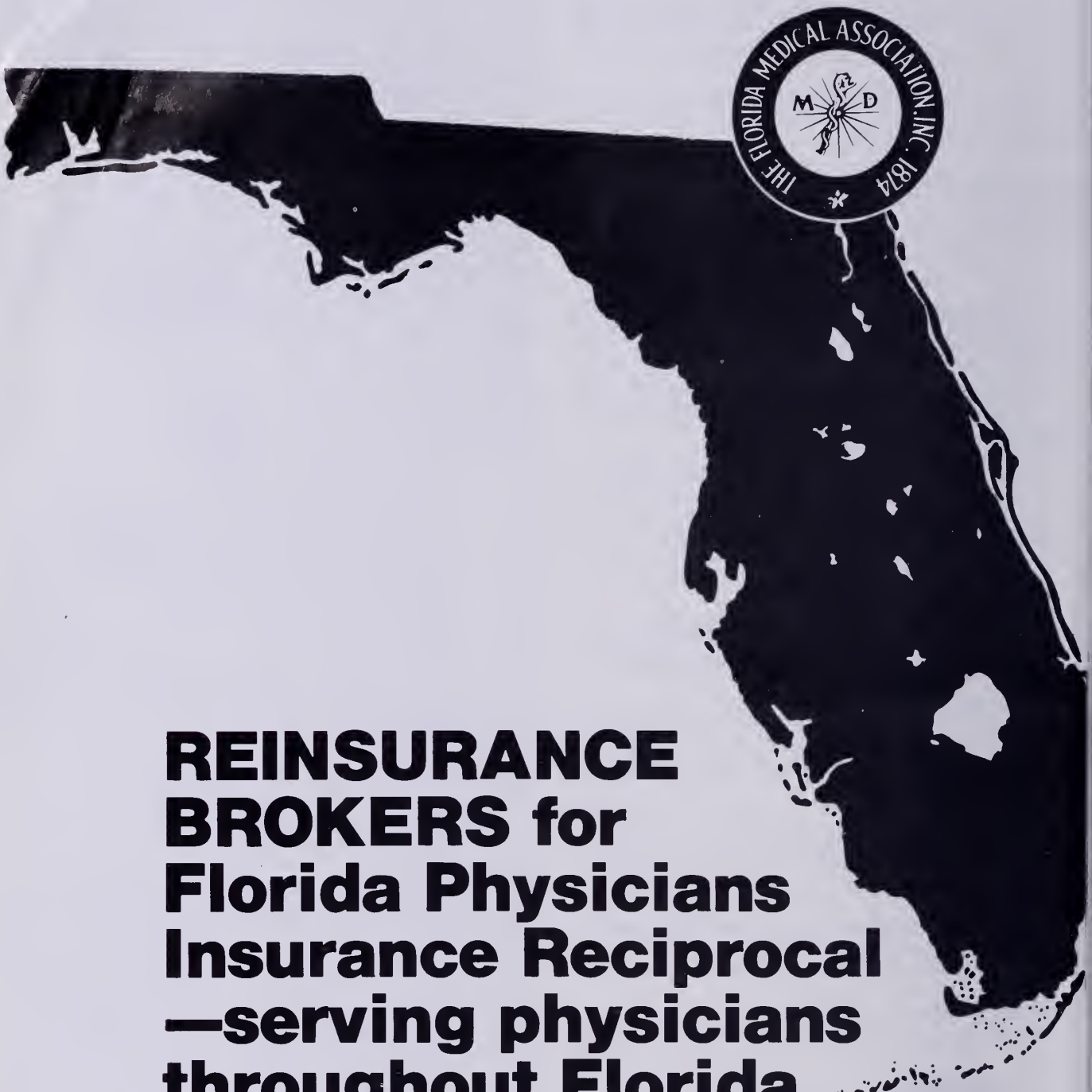
Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur.

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INTERNIST — Board Certified or eligible for established Miami Shores practice. Send Curriculum Vitae to Medical Business Consultants, 9999 N.E. 2nd Avenue, Suite 309, Miami Shores, Florida 33138.

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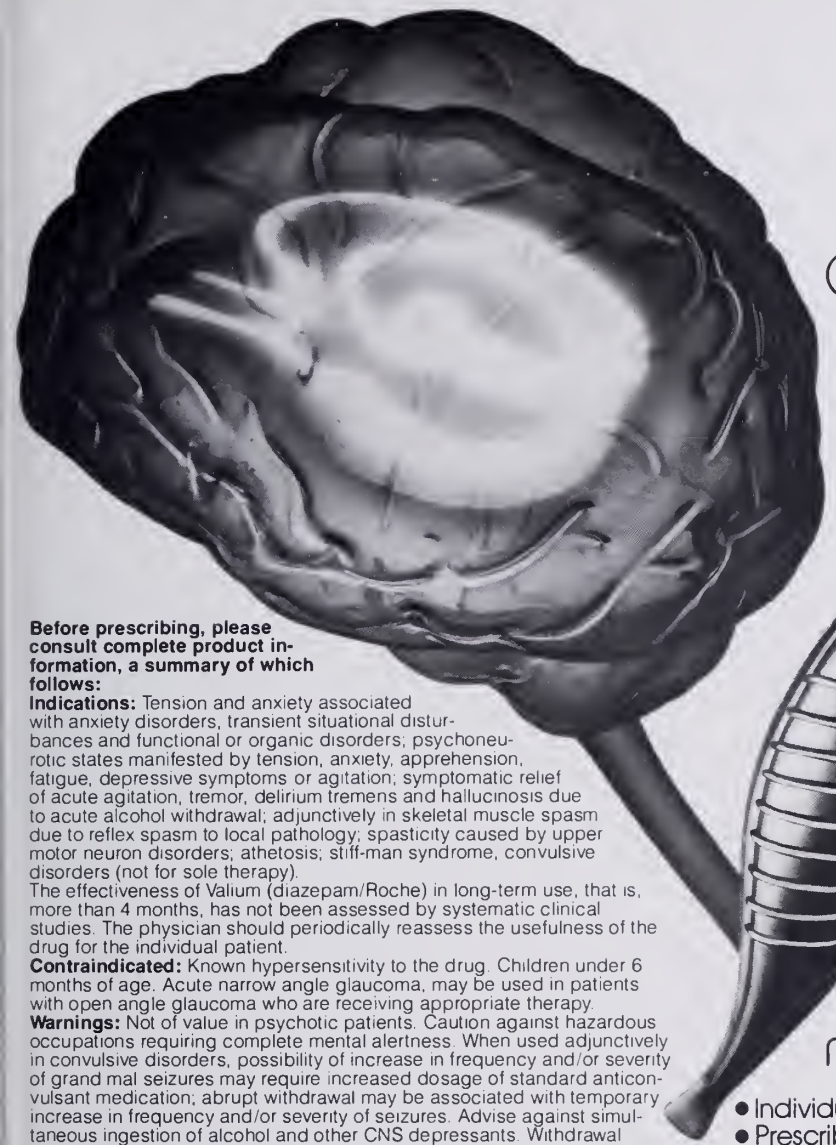
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Before prescribing, please consult complete product information, a summary of which follows:

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The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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General guidelines for the prescribing and appropriate use of minor tranquilizers

- Individualize dosage for maximal beneficial effect.
- Prescribe the specific quantity needed until the next checkup period, schedule frequent, periodic reexaminations to monitor results of therapy.
- Establish treatment goals and gradually discontinue medication when these have been met.
- Avoid prescribing for individuals who appear dependency-prone or whose histories indicate the potential for misuse of psychoactive substances, including alcohol.
- Caution patients against engaging in hazardous occupations requiring complete mental alertness such as operating machinery or driving.
- Advise patients against the ingestion of alcoholic beverages while undergoing therapy with minor tranquilizers.
- Counsel patients to follow label directions, keep medication out of children's reach, and dispose of unused or old medication.
- Caution patients against giving medication to others.
- Avoid abrupt cessation of extended therapy by tapering dosage before discontinuing medication.

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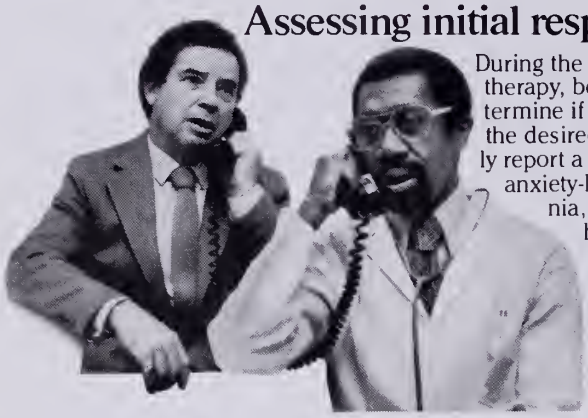
Historical Issue

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William M. Straight, M.D.
Guest Editor

Monitoring patient response to Valium® (diazepam/Roche)

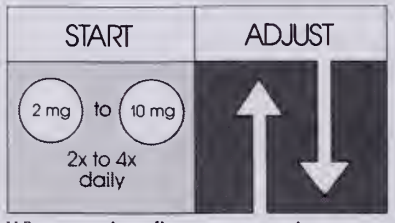
Assessing initial response to therapy



During the first follow-up visit after initiating therapy, both physician and patient should determine if Valium (diazepam/Roche) is having the desired effect. Most patients will promptly report a feeling of relaxation and relief of anxiety-linked symptoms such as insomnia, headaches, palpitations and hyperventilation. You will probably observe that the patient is calmer and more relaxed. If, however, patient response does not measure up to expectations, a reevaluation of the patient's profile with modification of the dosage regimen should be considered.



Making dosage adjustments



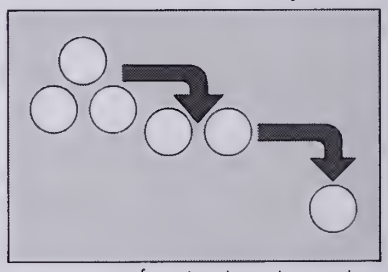
With any psychoactive medication it is good medical practice to initiate therapy at base dosage levels and titrate to the patient's needs. With Valium, experience has shown that 5 mg t.i.d. is usually sufficient although some patients with severe or persistent anxiety may require higher dosages initially. In geriatric or debilitated patients, the recommended dosage is 2 to 2½ mg once or twice daily. When anxiety fluctuates, as is common with most patients, the dosage may be adjusted as needed during the course of therapy; three strengths in scored tablets give you unmatched flexibility and simplicity in individualizing dosage.

Evaluating progress toward therapeutic goals

SET GOALS						
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

At the beginning of therapy it is now common practice for both physician and patient to establish treatment goals and to estimate the amount of time needed to achieve them. Then the patient knows what to expect and when to expect it. Some physicians find that compiling a checklist of presenting symptoms and complaints is useful for assessing the patient's response from visit to visit. In this way, progress toward attainment of the therapeutic goal is reviewed at regular intervals. As patients feel their symptoms abate and begin to develop insight into the sources of their anxiety and psychic tension, the checklist can be expected to dwindle.

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The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults.* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d., alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d., adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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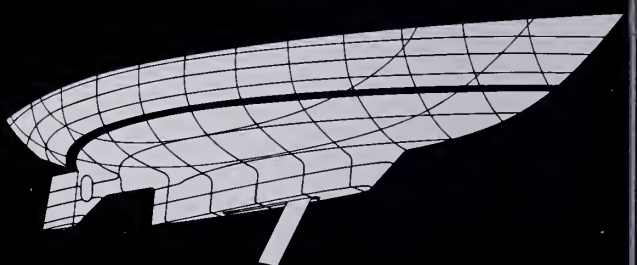
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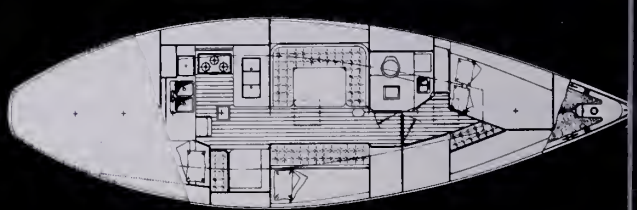
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AUGUST 1980 • VOL 67 • NO. 8 (ISSN 0015-4148)

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Howard's Grove Hospital, Richmond, Virginia, rendered by an unknown artist c. 1862-1864. Courtesy of the Chicago Historical Society.

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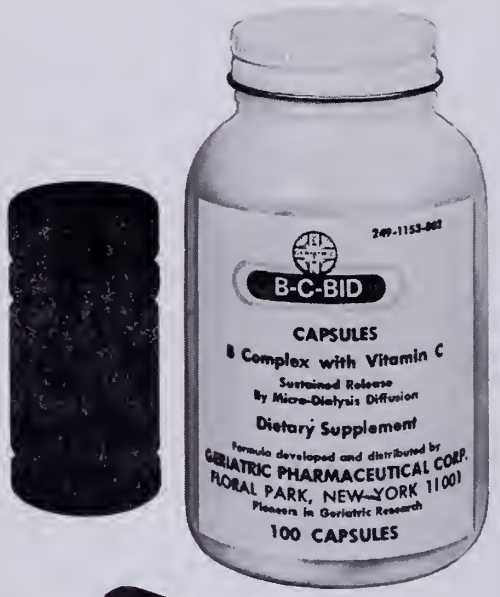
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President's Page

Thank You, Marie

I still remember the first day I saw her. She was the office manager and private secretary to my senior partner, Dr. Duncan McEwan, a Past President of the FMA. She interviewed me when I first applied to work with Dr. McEwan at the old Orlando Clinic building in 1958. She was tall and lovely and charming, as she is today. She taught me a lot about the business and art of the medical profession and always with patience and respect.

Through the years she became my private secretary while she continued to be the office manager in a group of doctors which will become eight in September. They are all diverse in interests and ideas and personalities. What would you expect with two general surgeons, two orthopedists, three family physicians and soon an internist? Through it all she has tried to maintain an efficient, effective, cohesive organization which rendered service to its patients with a feeling of personal caring — a reflection of her own genuine concern for all the clinic's patients.

I always thought we would retire together at some future unknown date. But recently she told me in her own quiet way that because of her husband's increasing travel needs in his business and her own personal desires she would be retiring soon. As always, she thought of what would be most convenient for us first and left the exact date open until we could find someone to assume her responsibilities. We can never find someone to replace her.

She did so many personal things as well as the office chores. She reminded me more than once of a birthday or anniversary or to send a personal note to someone. She organized my trips and meetings and schedules and saw that I got to the places I was supposed to be on time. And when I got all the accolades for her work she just quietly smiled and continued to do the job.

The realization of her leaving my office has made me especially aware of the effect our office assistants have on the success of our practice. The quality of medical care is just as dependent on the projection of concern and empathy by doctors and staff alike as it is upon the fountain of scientific knowledge we each possess. From our receptionists to our office personnel to our technicians and nurses we ought to stop a moment and express our gratitude for the tremendous job they do for each of us everyday.

And so, Marie, I take this way to thank you, all of my staff and the associates of all the doctors in the Florida Medical Association for all you do for each of us. Thank you and God Bless.

T. Byron Thomas MD



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Editorial

This Issue

While some wag once said that history is merely gossip grown respectable with age, Aristotle, in the Poetics discounts history on the ground that it merely records particular facts and does not, like drama, depict the general truths of a consistent plot. Gaining a sense of tradition from their myths, however, Greeks were able to measure their traditions against the antiquity of the east and recognize the importance of first hand inquiry, a root meaning of history. Interested in the factors of human behavior that influenced questions of aggression and security, the Greeks probed into the human passions underlying political action, drawing patterns of regularity in the varied interplay of human nature and political circumstances that make history. Judging human motives, they wrote a moralizing history by describing an interplay of human and divine acts, the ambitions of individuals and the rivalries of the states. Roman history was influenced by Helenistic learning but their elegant reporting was often used to influence public opinion.

Christian writers, believing that God exercised control over events in the interest of man's salvation, rearranged facts and interpreted them for better understanding. Stating that good and evil strive against each other on the stage of history, with time and study, they avowed that the pattern of history displays hints and intimation of a divine activity rather than any precise or ordered regularity.

The belief that it is possible to discern in the course of human history some general scheme or design is supported by the basic demand for an orderly system which constitutes one element in the human mind and consciousness. Not to do so implies a skepticism concerning the value of human life and existence and represents an affront to the dignity of human nature.

While many writers believe that the historical process considered as a whole is both rational and morally comprehensible with its theological origins, those with a scientific approach propound a cyclical theory describing man's nature as an historical animal whose activities are subject to change and development in the course of time according to complex and pervasive influences.

Jumping a thousand years or so, to the first meeting of the Florida Medical Association in 1874, a secretary took the minutes in longhand and only at the second annual meeting on February 17th, 1875 did a committee on publication have printed 250 copies of the two meetings which were mailed to every member. It was 31 years later before a resolution appeared to undertake the publishing of a journal, and at the 40th annual meeting in 1914 in Miami, a resolution was adopted to establish our state journal. The first issue appeared in July of that year. There was little history in these early issues but by reading the editorials and the proceedings of the annual meetings, one can surmise the course of our state association in these early years.

In 1950 Webster Merritt of Jacksonville dug into the activity of physicians in Florida and wrote many historical articles for *The Journal.* History became more popular in the next decade when one issue of *The Journal* each year was devoted to the history of medicine in our state. A single physician history buff has been the motivating force behind every one of these special issues and in 1968 he became the historical editor. Having worked with him over the last ten to twelve years, the state-wide recognition of his knowledge was unknown to me until some research was attempted to obtain details of the re-organization of the Duval County Medical Society in 1865 when Jacksonville physicians who had been absent working with armies on both sides of the War Between the States returned home to resume practice. Covering a number of years, this research involved contacting libraries all over the country and personal communication with the librarians at the University of Florida, Florida State University and the University of South Florida in Tampa. These inquiries brought forth few details but in almost every one of these communications, there appeared the advice to look up the work of Dr. Webster Merritt and Dr. William Straight of Miami. Dr. Straight, currently a Clinical Professor of Medical History at the University of Miami School of Medicine, has engineered a special issue of *The Journal* for many years by personally writing on the

history of Florida medicine and encouraging other physicians to assit him. In 1974, he was the historical editor of the FMA centennial issue.

A true historiographer, Bill fulfills the definition in Webster's Dictionary as one designated by a group for the practice of historiography, which is the principle of methodology of historical study and as the word has a Greek root, "histor", meaning a learned man, it is obvious why he has been selected as the official historian of the Florida Medical Association.

Whatever one's beliefs on the philosophy of history, it is quite apparent that we are deeply indebted to Dr. Straight for his works over the years and for this special issue.

C.M.C.



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Precautions: *Because the target symptoms are of unknown etiology, careful diagnosis should be attempted before prescribing Hydergine tablets and sublingual tablets.*
Adverse Reactions: Serious side effects have not been found. Some sublingual irritation, transient nausea, and gastric disturbances have been reported. Hydergine tablets and sublingual tablets do not possess the vasoconstrictor properties of natural ergot alkaloids.
Dosage and Administration: 1 mg three times daily. Alleviation of symptoms is usually gradual and results may not be observed for 3–4 weeks.
How Supplied: Hydergine tablets (for oral use) 1 mg, packages of 100 and 500. **Hydergine sublingual tablets 1 mg,** containing dihydroergocornine mesylate 0.333 mg, dihydroergocristine mesylate 0.333 mg, and dihydroergocryptine (dihydro-alpha-ergocryptine and dihydro-beta-ergocryptine in the proportion of 2:1) mesylate 0.333 mg, representing a total of 1 mg; packages of 100, 500, and 1000. **Hydergine sublingual tablets 0.5 mg,** containing dihydroergocornine mesylate 0.167 mg, dihydroergocristine mesylate 0.167 mg, and dihydroergocryptine (dihydro-alpha-ergocryptine and dihydro-beta-ergocryptine in the proportion of 2:1) mesylate 0.167 mg, representing a total of 0.5 mg; packages of 100 and 1000.
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Going Bare

Doctors seeking a port in the malpractice storm aren't likely to find it by going bare. That's the impression I brought away from a recent meeting of the Association of Trial Lawyers of America in Las Vegas. This is a highly charged issue in some sectors of the legal profession. As one crusty courtroom veteran put it when I asked him what he'd do if he discovered that a doctor he's sued carried no malpractice insurance, "I'd skin him alive and nail his hide to the courtroom door!"

Tough talk, but keep in mind that we're dealing mostly with plaintiff's lawyers — those who make their living representing patients in malpractice suits — and they're not exactly objective.

"Doctors who go bare are living in a fool's paradise," says Alfred S. Julien, a nationally known attorney in New York City. "They think either they won't get sued or the plaintiff's lawyer will drop the suit when he finds there's no insurance there. Anyone who believes that can wake up and find he's been kicked in his assets. Most doctors are in a high-income bracket, they've accumulated property and money, and a good lawyer knows how to go after it to satisy a judgment."

The consequences of going bare can be even more immediate, Julien notes. "If it becomes known in a community that a doctor is practicing without malpractice insurance," he says, "that may well turn patients away. And a referring physician would certainly think twice before sending patients to an uninsured doctor."

John Carlova, Medical Economics (April 14, 1980)

CIRCUBID™ 150 MG

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Circubid is a prolonged release capsule containing 150 mg ethaverine hydrochlonda Ethaverine (ethyl papaverine) is a more active derivative of papaverine obtained by the synthetic replacement of four side methoxy groups Ethaverine induces the direct relaxation of vascular smooth muscle which may improve circulation. Circubid (ethaverine hydrochlonde) may be particularly useful for nocturnal leg cramps and paresthesia exhibited as cold hands and feet For the genatric, the prolonged release of Circubid (ethaverine hydrochlonde) with a simplified b i d dosage increases compliance and realizes continuous benefits, especially in the forgetful patient The incidence of side effects is equal or less than a placebo as shown in clinical studies * **Prescribe Circubid for the symptoms that are of major concern to your geriatric patient.**

* William J Oswald, M D , "Pharmacology of Ethaverine HCl" *Southern Medical Journal*, December 1975 - Vol 68, No 12



Each capsule* contains: Ethaverine HCl, 150 mg **Action:** Ethaverine HCl, acts directly on the smooth muscle cells without involving the autonomic nervous system or its receptors **Indications:** In penpheral and cerebral vascular insufficiency associated with arterial spasm, in spastic conditions of the gastro-intestinal and genitounnary tracts. **Contraindications:** Contraindicated in the presence of complete atnoventricular dissociation. **Precautions:** It should be administered with caution in patients with glaucoma It should not be used in pregnant women or women of childbearing age unless directed by a physician **Adverse reactions:** Even though the incidence of side effects as reported in literature is very low, it is possible for the patient to evidence nausea, anorexia, abdominal distress, dryness of the throat, hypotension, flushing, sweating, vertigo, respiratory depression, cardiac depression, cardiac arrhythmia and headache If these side effects occur, reduce dosage or discontinue medication **Dosage:** The usual adult dose is 300 mg daily, one capsule every 12 hours In more difficult cases the dosage may be increased to 600 mg daily as determined by the physician It is most effective given early in the course of the vascular disorder Because of the chronic nature of the disease, long term therapy is required

* Manufactured to provide a prolonged therapeutic effect

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But milk supplies more essential nutrients per calorie than most other foods.

A child between the ages of six months and six years, for example, can get at least three-fourths of his daily dietary allowance for calcium, riboflavin, vitamins D and B_{12}, phosphorous, and protein from just three glasses of milk. And milk is also a good source of vitamins A and B_6, as well as thiamin and niacin (please see chart).

That's why the U.S.D.A., acting on the recommendation of the National Research Council—National Academy of Sciences, has established these guidelines for milk consumption:

Children up to 6 years
Two to three 8 oz. glasses per day.

Children 6 to 12 years
Three or more 8 oz. glasses per day.

For a free copy of the Dairy Council Digest issue titled, "Composition and Nutrient Value of Dairy Foods," contact your local Dairy Council or write the National Dairy Council, 6300 North River Road, Rosemont, Illinois 60018.

Per cent of Recommended Daily Allowance contributed by three 8 oz. glasses of fortified milk.

	6 mos.—1 yr.	1 yr.—3 yrs.	3 yrs.—6 yrs.
Calcium	100%	100%	100%
Riboflavin	100	100	100
Vitamin B_{12}	100	100	100
Protein	100	100	80
Phosphorus	100	85	85
Vitamin B_6	76	51	34
Vitamin D	75	75	75
Niacin*	71	63	47
Thiamin	56	40	31
Vitamin A	46	46	37

*maximum niacin equivalents based on:
60 mg tryptophan=1 mg niacin

ndc **National Dairy Council**

Milk. Sometimes we forget all the good things it does.



Dean's Page

The Health of the Academic Health Center

Emanuel M. Papper, M.D.

The external forces in American society nationally have many and complex effects including those upon the academic health centers of our nation. It would be folly in a short essay to attempt to explore thoroughly and in depth the nature of all of these effects, but they have gotten serious enough to deserve the attention of the practicing medical profession and also that segment of the profession whose major activities are concerned with the education of medical students, research and those activities commonly associated with the academic health center.

The inflation and economic ills that are well known to the readership of this *Journal* have taken a very specific effect in the various levels of government which produce untold havoc upon those areas in which we have a mutual interest. It is short-sighted and parochial, indeed, to claim that our particular interests deserve a special exemption from the societal ills which a government fumbling for a solution is attempting to find. However, one of the clear activities in Washington has been a significant curtailment of the activities which will lead to the development of new knowledge called research and ultimately, therefore, to the betterment of our nation's health. Even the delivery aspects of health care are at best compromised and at worst, seriously threatened. One can understand the need of a government to develop its economic priorities, but it is in the long run, short-sighted to think of the intellectual, as well as the practical health "industry" as one deserving a low priority from the standpoint of federal support. It looks very clearly as though the Medical Schools of this nation will be in serious trouble because of these federal cutbacks and the serious questions on how to continue an unmodified high-quality of medical education and academic health center activities is there and is difficult for any to find adequate solutions.

I do not believe that anyone would think that the quality should be diluted in order to reduce costs. I doubt that one could find constituents for making the medical profession a "rich man's" or "rich woman's" profession. A spiraling tuition spector is ever looming in this regard.

In addition to sharply reducing the potential of research efforts and the support of education, there are other almost ominous implications.

It has been well documented for a long time that even in the most heavily supported of private institutions that private philanthropy, crucial and important though it is, does not account for, on the average, more than somewhere between 2% and 4% of the total support system of the academic health center.

We, therefore, are compelled to find other solutions. One of the evident solutions that is possible, but unless carefully handled in collaboration with the academic health center and the practicing community, could lead to unnecessary and unwanted conflict. It is becoming increasingly plain the country over that the clinical activities of the clinical faculty can and must be relied upon increasingly as a means for the support of medical education. Apart from the potential conflict with the practicing community, the intellectual and philosophical question quite properly arises as to why clinicians should willingly spend much of their energy and time so that young people can receive a medical education and perhaps, even more far-fetched why their colleagues in the basic sciences should receive replacement support from these sources. These are questions that have no easy answer, but they have to be laid out in the open for all to contemplate and to consider.

It seems to this observer that when times are very black and bleak — and they are — there is an opportunity for creativity to those few who have the insight. This observer does not pretend to have that kind of insight, but it does require extensive discussion, frank exploration of our mutual problems, so that the practicing profession and the smaller part of the profession devoted to education and research may find some means of mutual reinforcement so that we may all thrive to reasonable degree.

Dr. Papper is Vice President for Medical Affairs and Dean of the School of Medicine, University of Miami, Miami, Florida.

● Dr. Papper, University of Miami School of Medicine, Box 875, Biscayne Annex, Miami, Florida 33152.

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FROM THE EDITOR'S DESK

IRS CAUTIONS EMPLOYERS

The Internal Revenue Service has issued a warning to Florida employers regarding the proper handling of withholding taxes. Monitoring of the remittance of withholding taxes is being stepped up by IRS due to the economic downturn. The penalties for failing to comply with IRS regulations include filing of federal tax liens, seizure and sale of the business, or possible criminal charges.

SOUTHERN MEDICAL NAMES NEW EXEC

William J. Ranieri will succeed Robert F. Butts as the new Executive Vice President and Chief Executive Officer of the 26,000-member Southern Medical Association this month. Mr. Ranieri is former CEO of the Alabama Hospital Association, and had previously worked with the Veterans Administration in Chicago, the American Hospital Association and the American College of Hospital Administrators.

PATHOLOGISTS CHALLENGE MEDICARE POLICY CHANGE

The College of American Pathologists and six other plaintiffs have filed suit in U.S. District Court for the Eastern District of Arkansas challenging a change in Medicare policy on reimbursement to hospital based physicians. The suit, which names Department of Health and Human Services Secretary Patricia R. Harris as defendant, challenges a change in Medicare regulations which would disallow reimbursement after July 1, 1980, to pathologists for the professional component of clinical pathology services under Part B of Medicare.

DEMOCRATS HEAR AMA TESTIMONY

AMA Board Chairman Lowell H. Steen, M.D., testified before the Democratic Platform Committee in Washington, D.C., and urged the Party to call for federal support of the private sector in a plank aimed at continued strengthening of the quality of medical care and ensuring accessibility to care. Dr. Steen also recommended that the platform "include a strong statement urging the reduction of federal regulation overall and the elimination of unnecessary federal regulation in medicine."

NEW HEAD OF HEALTH CARE FINANCING ADMINISTRATION

Howard Newman, President of the Dartmouth-Hitchcock Medical Center, has been named Administrator of the Health Care Financing Administration, the HHS agency that runs the Medicare and Medicaid programs.

CARTER SIGNS DIRECTIVE CURBING SPENDING

President Carter has signed a directive designed to curb federal spending for unnecessary construction and renovation of both federal and non-federal hospitals. Deleted from the order was a key provision stating, "State and local health planning agencies will be asked to review and comment on proposed federal construction, and their findings will be considered in the (budget) review process." The directive calls for executive agency review of federal spending for federally owned and operated facilities such as Veterans Administration hospitals, review of subsidies for non-federal hospital construction, review of Medicare-Medicaid reimbursement for capital costs, and consideration of legislation to cut off funding through tax exempt bonds.

TWO YEAR HHS STUDY LAUNCHED

A two-year HHS study is being launched to weigh the ethical and economic problems of providing heart transplants as a Medicare benefit. HHS Secretary Patricia Harris commented that new medical technologies and techniques "demand that we develop a rational process that makes it possible to define what constitutes 'reasonable and necessary' medical services which can be funded by Medicare in the case of heart transplants and other procedures." Medicare has financed 23 transplants over the years.

The Editor

Worker's Compensation Fee Schedule Increased as of July 1

A 35% increase in the Division of Worker's Compensation Medical and Surgical Fee Schedule went into effect on July 1, the result of a petition and testimony by the Florida Medical Association.

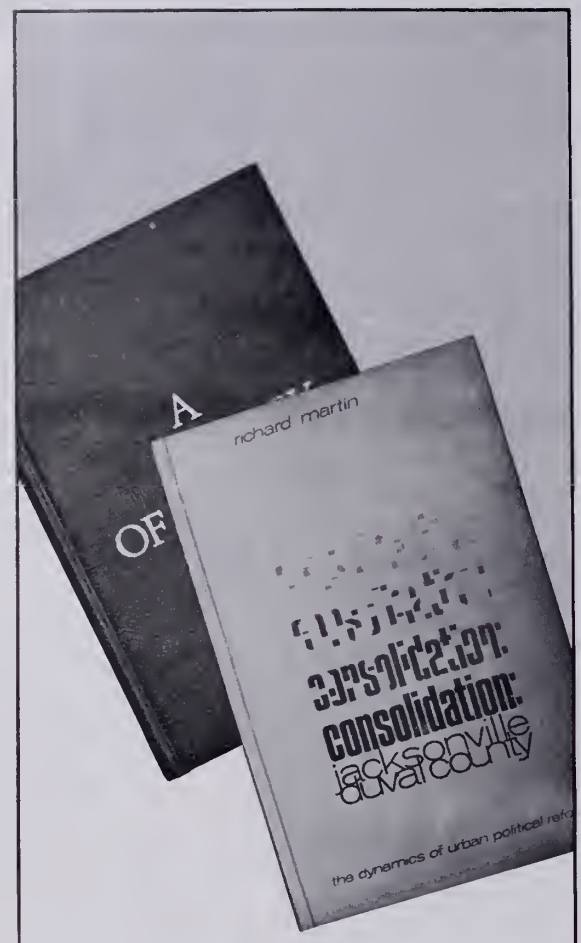
According to FMA President T. Byron Thames, M.D., the Division is experiencing a delay in printing the new fee schedule. Until the new schedule becomes available, physicians should bill on the basis of the February 1, 1978 schedule, plus 35% and rounded to the nearest dollar.

The following payments have been approved for office visits, hospital visits and consultations:

Office Visits (New Patients) — brief history and examination, $18; intermediate history and examination, $22; and comprehensive history and examination, $32. **Office Visits (Established Patients)** — brief examination, $11; intermediate examination, $15; and comprehensive re-examination, $20.

Hospital Visits (New or Established Patients) — initial hospital care, brief history and examination, $21; initial hospital care, intermediate history and examination, $27; and initial hospital care, comprehensive history and examination, $31. **Hospital Visits (Established Patient Follow-Up Care)** — brief examination, $14; intermediate examination, $15; and extended re-examination, $20.

Consultations — limited, $35; intermediate, $40; extensive, $45; comprehensive, $55; and complex, $65.



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(diethylpropion hydrochloride NF)

Tenuate Dospan®
(diethylpropion hydrochloride NF) controlled-release

AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.

CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).

WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. *Drug Dependence*: Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. *Use in Pregnancy*: Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children*: Tenuate is not recommended for use in children under 12 years of age.

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

ADVERSE REACTIONS: *Cardiovascular*: Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System*: Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal*: Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic*: Urticaria, rash, ecchymosis, erythema, *Endocrine*: impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System*: Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous*: A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in midevening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg tablet daily, swallowed whole, in midmorning. Tenuate is not recommended for use in children under 12 years of age.

OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

Product Information as of April, 1976

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References: 1. Citations available on request from Medical Research Department, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M.T., O'Dillon [Dillon], R.H., and Leyland, H.M.: A comprehensive review of diethylpropion hydrochloride In: Central Mechanisms of Anorectic Drugs, S. Garattini and R. Samanin, Ed., New York, Raven Press, 1978, pp. 391-404

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Overweight may not always be simple... complications can develop.*

Complicated or not...

Tenuate® Dospan® ℞

(diethylpropion hydrochloride NF)

75 mg. controlled-release tablets



A useful short-term adjunct in an indicated weight loss program.

Overweight patients in certain diagnostic categories often require strict appetite control and a successful program of weight reduction may tend to diminish the incidence or severity of the complications in some patients. Diethylpropion hydrochloride has been reported useful in such patients and while it is not suggested that Tenuate itself in any way reduces the complications of overweight, it may have a useful place as a short-term adjunct in a prescribed dietary regimen. **Tenuate should not be administered to patients with severe hypertension; see additional Warnings and Precautions on the opposite page.**

In uncomplicated overweight.

Many patients, on the other hand, present with excess fat but no disease. While this condition is often termed uncomplicated obesity, complications of both a social and a psychologic nature may be distressingly real for the patients. In these cases, a short-term regimen of Tenuate can help reinforce your dietary counsel during the important early weeks of an indicated weight loss program.

Clinical effectiveness.

The anorectic effectiveness of diethylpropion hydrochloride is well documented. No less than 16 separate double-blind, placebo-controlled studies attest to its usefulness in daily practice.[1] And the unique chemistry of Tenuate provides "...anorectic potency with minimal overt central nervous system or cardiovascular stimulation."[2] Compared with the amphetamines, diethylpropion has minimal potential for abuse.

Tenuate—it makes sense. And it's responsible medicine.

*Studies have shown that obesity is associated with an increased incidence of hypertension, symptomatic heart disease, adult-onset diabetes, and other diseases.

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For prescribing information see opposite page.

Alpha Stimulation

Central Control of Blood Pressure*



"The Family of Man" by Roberto Moretti,
a statuary in crystal symbolizing the broad range of
hypertensive patients eligible for therapy with Catapres.

The Alpha Advantage:

It's for all kinds of hypertensives

- *Unlike beta blockers, Catapres® has no contraindications.*
- *Catapres can be useful even in these patients with:*

Congestive heart failure	Allergic rhinitis
Ventricular hypertrophy	Hepatic disease
Hyperglycemia	Hyperuricemia
Diabetes mellitus	Gouty arthritis
Bronchial asthma	Sulfonamide hypersensitivity

Like any antihypertensive, use with caution in severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

work/play—normal hemodynamic responses to exercise maintained.

love—low incidence of impotence and/or loss of libido: 2.8% in 1,923 patients studied.[1]

cardiac output—tends to return to control values during long-term therapy.

blood flow—preserved in kidney.

No Single Advantage Determines Drug Choice.

Other factors must include:

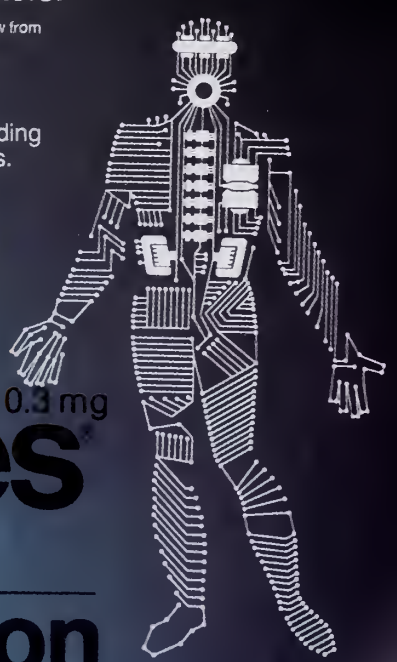
The drug's effectiveness in a given patient, its side effects, warnings, precautions, tolerance, etc. A rational therapeutic choice depends on a careful assessment of all such factors.

*Central alpha-adrenergic stimulation decreases sympathetic outflow from the brain, as shown in animal studies.

1. Data on file at Boehringer Ingelheim Ltd.

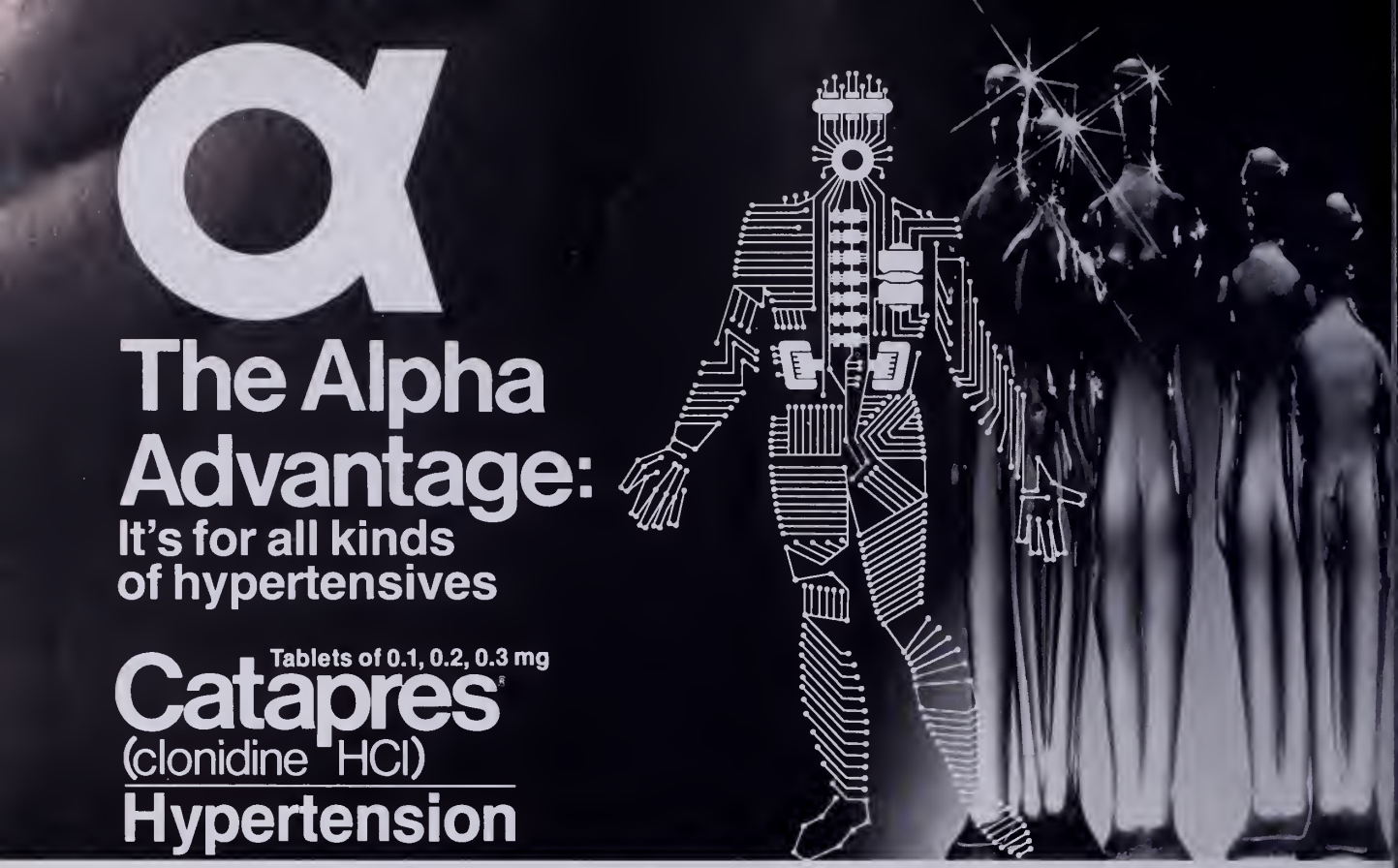
Please see last page for brief summary, including warnings, precautions, and adverse reactions.

Now available in new 0.3 mg tablets



Tablets of 0.1, 0.2, 0.3 mg

Catapres®
(clonidine HCl)
Hypertension



The Alpha Advantage:

It's for all kinds of hypertensives

Tablets of 0.1, 0.2, 0.3 mg

Catapres®

(clonidine HCl)

Hypertension

- No contraindications.
- Effective in all degrees of hypertension. It is mild to moderate in potency.
- Low incidence of depression, impotence, orthostatic hypotension—no fatal hepatotoxicity.
- Preserves kidney blood flow.

Most common side effects are dry mouth, drowsiness, and sedation which generally tend to diminish with time.

The usual starting dose of Catapres is 0.1 mg at brea fast and 0.1 mg at bedtime. Some patients may bene from a starting dose of 0.1 mg at bedtime.

Usual daily dose range—0.2—0.8 mg

Maximum daily dose—2.4 mg
Doses as high as this have rarely been employed.

For optimal results, the dose of Catapres must be adjusted according to the patient's individual blood pressure response.

Catapres®
(clonidine hydrochloride)
Tablets of 0.1, 0.2, 0.3 mg

Indication: The drug is indicated in the treatment of hypertension. As an antihypertensive drug, Catapres (clonidine hydrochloride) is mild to moderate in potency. It may be employed in a general treatment program with a diuretic and/or other antihypertensive agents as needed for proper patient response.

Warnings: Tolerance may develop in some patients necessitating a reevaluation of therapy.
Usage in Pregnancy: In view of embryotoxic findings in animals, and since information on possible adverse effects in pregnant women is limited to uncontrolled clinical data, the drug is not recommended in women who are or may become pregnant unless the potential benefits outweigh the potential risk to mother and fetus.
Usage in Children: No clinical experience is available with the use of Catapres (clonidine hydrochloride) in children.

Precautions: When discontinuing Catapres (clonidine hydrochloride), reduce the dose gradually over 2 to 4 days to avoid a possible rapid rise in blood pressure and associated subjective symptoms such as nervousness, agitation, and headache. Patients should be instructed not to discontinue therapy without consulting their physician. Rare instances of hypertensive encephalopathy and death have been recorded after cessation of clonidine hydrochloride therapy. A causal relationship has not been established in these cases. It has been demonstrated that an excessive rise in blood pressure, should it occur, can be reversed by resumption of clonidine hydrochloride therapy or by intravenous phentolamine. Patients who engage in potentially hazardous activities, such as operating machinery or driving, should be advised of the sedative effect. This drug may enhance the CNS-depressive effects of alcohol, barbiturates and other sedatives. Like any other agent lowering blood pressure, clonidine hydrochloride should be used with caution in patients with severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

As an integral part of their overall long-term care, patients treated with Catapres (clonidine hydrochloride) should receive periodic eye examinations. While, except for some dryness of the eyes, no drug-related abnormal ophthalmologic findings have been recorded with Catapres (clonidine hydrochloride), in several studies the drug produced a dose-dependent increase in the incidence and severity of spontaneously occurring retinal degeneration in albino rats treated for 6 mo longer.

Adverse Reactions: The most common reactions are dry mouth, drowsine sedation. Constipation, dizziness, headache, and fatigue have been re Generally these effects tend to diminish with continued therapy. The fo reactions have been associated with the drug, some of them rarely. (Ir instances an exact causal relationship has not been established.) These ir Anorexia, malaise, nausea, vomiting, parotid pain, mild transient abnorma liver function tests; one report of possible drug-induced hepatitis without and hyperbilirubinemia in a patient receiving clonidine hydrochloride, thalidone and papaverine hydrochloride. Weight gain, transient elevation o glucose, or serum creatine phosphokinase: congestive heart failure, Ray phenomenon; vivid dreams or nightmares, insomnia, other behavioral ch nervousness, restlessness, anxiety and mental depression. Also ras gioneurotic edema, hives, urticaria, thinning of the hair, pruritus not ass with a rash, impotence, urinary retention, increased sensitivity to alcohol, d itching or burning of the eyes, dryness of the nasal mucosa, pallor, gynecor weakly positive Coombs' test, asymptomatic electrocardiographic abnorr manifested as Wenckebach period or ventricular trigeminy.

Overdosage: Profound hypotension, weakness, somnolence, diminished sent reflexes and vomiting followed the accidental ingestion of Catapres (cl hydrochloride) by several children from 19 months to 5 years of age. covery within 24 hours. Tolazoline in intravenous doses of 10 mg at 30- intervals usually abolishes all effects of Catapres, (clonidine hydrochloride dosage.

How Supplied: Catapres, brand of clonidine hydrochloride, is available as (tan) and 0.2 mg (orange) oval, single-scored tablets in bottles of 100 and 100 available as 0.3 mg (peach) oval, single-scored tablets in bottles of 100.

For complete details, please see full prescribing information.
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A non-narcotic one-two punch against pain, with concurrent relief of anxiety/tension

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meprobamate and ethoheptazine citrate with aspirin) Wyeth

QUAGESIC—Abbreviated Summary

INDICATIONS: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows

"Possibly" effective for the treatment of pain accompanied by tension and/or anxiety in patients with musculoskeletal disease or tension headache.

Final classification of the less-than-effective indications requires further investigation.

The effectiveness of Equagesic in long-term use, i.e. more than four months, has not been assessed by systematic clinical studies. The physician should periodically reassess usefulness of the drug for the individual patient.

ONTRAINDICATIONS: Equagesic should not be given to ividuals with a history of sensitivity or severe intolerance aspirin, meprobamate, or ethoheptazine citrate.

ARNINGS: Careful supervision of dose and amounts prebed for patients is advised, especially with those patients h known propensity for taking excessive quantities of drugs. cessive and prolonged use in susceptible persons, e.g., oholics, former addicts, and other severe psychoneurot-, has been reported to result in dependence on or habition to the drug. Where excessive dosage has continued weeks or months, dosage should be reduced gradually her than abruptly stopped since withdrawal of a "crutch" ay precipitate withdrawal reaction of greater proportions an that for which the drug was originally prescribed. Abrupt continuance of doses in excess of the recommended dose s resulted in some cases in the occurrence of epileptiform zures.

ecial care should be taken to warn patients taking meproate that tolerance to alcohol may be lowered with reltant slowing of reaction time and impairment of judgement d coordination.

AGE IN PREGNANCY AND LACTATION: An increased risk of congenital malformations associated with use of minor tranquilizers (meprobamate, chlordiazepoxide, and diazepem) during the first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of child-bearing potential may be pregnant at the time of institution of therapy should be considered. Patients should be advised that if they become pregnant during therapy or intend to become pregnant they should communicate with their physicians about the desirability of discontinuing the drug.

Meprobamate passes the placental barrier. It is present both in umbilical-cord blood at or near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breast-feeding patients, the drug's higher concentrations in breast milk as compared to maternal plasma levels should be considered.

Preparations containing aspirin should be kept out of the reach of children. Equagesic is not recommended for patients 12 years of age and under.

PRECAUTIONS: Should drowsiness, ataxia, or visual disturbance occur, the dose should be reduced. If symptoms continue, patients should not operate a motor vehicle or any dangerous machinery.

Suicidal attempts with meprobamate have resulted in coma, shock, vasomotor and respiratory collapse, and anuria. Very few suicidal attempts were fatal, although some patients ingested very large amounts of the drug (20 to 40 gm). These doses are much greater than recommended. The drug should be given cautiously, and in small amounts, to patients who have suicidal tendencies. In cases where excessive doses have been taken, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels. Hyperventilation has been reported occasionally. Any drug remaining in the stomach should be removed and symptomatic treatment given. Should respiration become very shallow and slow, CNS stimulants, e.g., caffeine, Metrazol, or amphetamine, may be cautiously administered. If severe hypotension develops, pressor amines should be used parenterally to restore blood pressure to normal levels.

ADVERSE REACTIONS: A small percentage of patients may experience nausea with or without vomiting and epigastric distress. Dizziness occurs rarely when meprobamate and ethoheptazine citrate with aspirin is administered in recommended dosage. The meprobamate may cause drowsiness but, as a rule, this disappears as therapy is continued. Should drowsiness persist and be associated with ataxia, this symptom can usually be controlled by decreasing the dose, but occasionally it may be desirable to administer central stimulants such as amphetamine or mephentermine sulfate concomitantly to control drowsiness.

A clearly related side effect to the administration of meprobamate is the rare occurrence of allergic or idiosyncratic reactions. This response develops, as a rule, in patients who have had only 1-4 doses of meprobamate and have not had a previous contact with the drug. Previous history of allergy may or may not be related to the incidence of reactions.

Mild reactions are characterized by an itchy urticarial or erythematous, maculopapular rash which may be generalized or confined to the groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema, and fever have also been reported.

More severe cases, observed only very rarely, may also have other allergic responses, including fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case), and hyperthermia. Treatment should be symptomatic such as administration of epinephrine, antihistamine, and possibly hydrocortisone. Meprobamate should be stopped, and reinstitution of therapy should not be attempted.

Rare cases have been reported where patients receiving meprobamate suffered from aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia. In nearly every instance reported, other toxic agents known to have caused these conditions have been associated with meprobamate. A few cases of leukopenia during continuous administration of meprobamate are reported, most of these returned to normal without discontinuation of the drug.

Impairment of accommodation and visual acuity has been reported rarely.

OVERDOSE: Two instances of accidental or intentional significant overdosage with ethoheptazine citrate combined with aspirin have been reported. These were accompanied by symptoms of CNS depression, including drowsiness and light-headedness, with uneventful recovery. However, on the basis of pharmacological data, it may be anticipated that CNS stimulation could occur. Other anticipated symptoms would include nausea and vomiting. Appropriate therapy of signs and symptoms as they appear is the only recommendation possible at this time. Overdosage with ethoheptazine combined with aspirin would probably produce the usual symptoms and signs of salicylate intoxication. Observation and treatment should include induced vomiting or gastric levage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, it it occurs, usually requires whole-blood transfusions.

DESCRIPTION: Each Equagesic tablet contains 150 mg meprobamate, 75 mg ethoheptazine citrate and 250 mg aspirin.

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*This drug has been evaluated as possibly effective for this indication

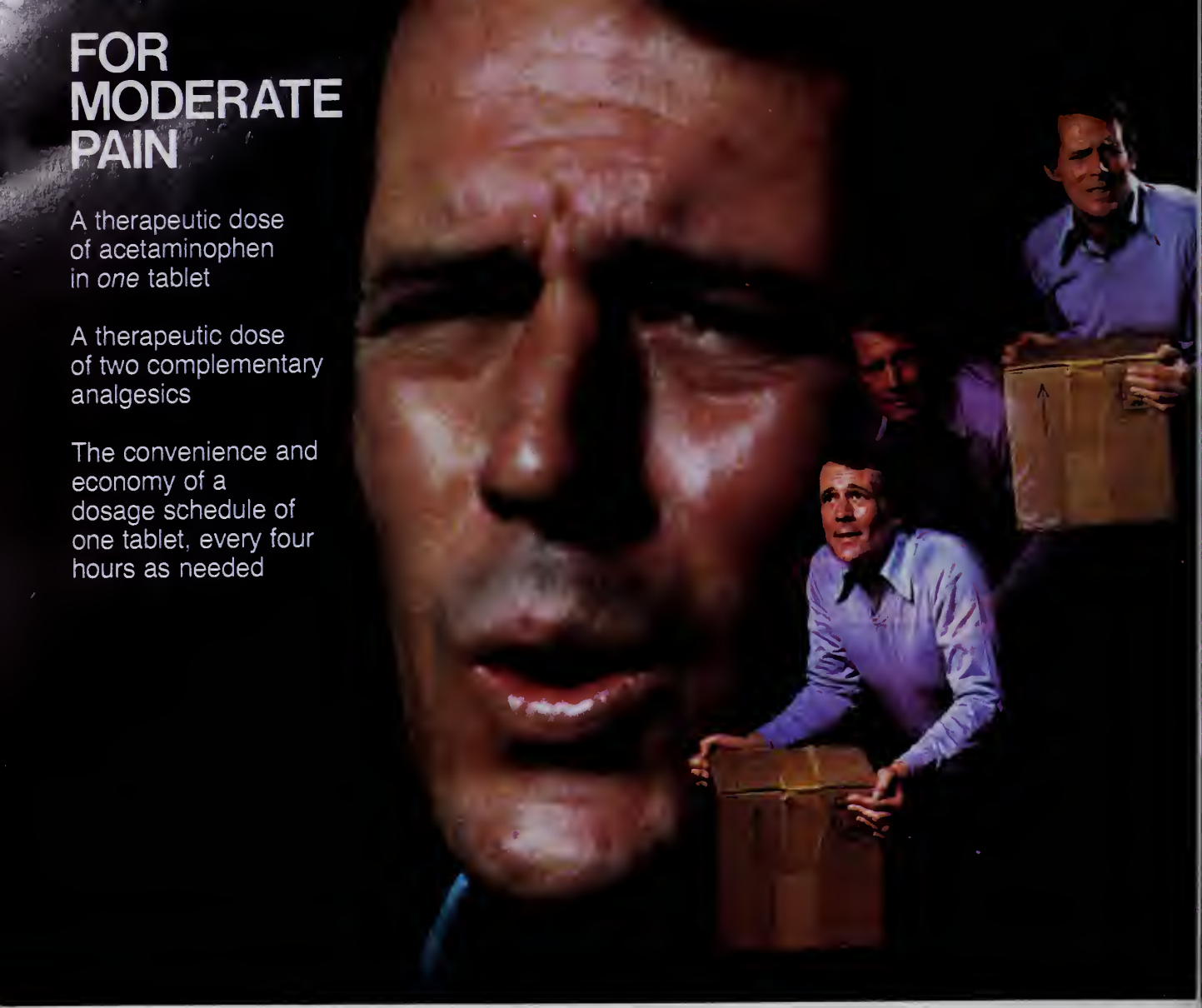
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WYGESIC—Abbreviated Summary

INDICATION: For the relief of mild-to-moderate pain.

CONTRAINDICATION: Hypersensitivity to propoxyphene or to acetaminophen.

WARNINGS: CNS ADDITIVE EFFECTS AND OVERDOSAGE. Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, or other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. Toxic effects and fatalities have occurred following overdoses of propoxyphene alone or in combination with other CNS depressants. Most of these patients had histories of emotional disturbances or suicidal ideation or attempts, as well as misuse of tranquilizers, alcohol, or other CNS-active drugs. Caution should be exercised in prescribing large amounts of propoxyphene for such patients (see **Management of Overdosage**).

DRUG DEPENDENCE: Propoxyphene can produce drug dependence characterized by psychic dependence and less frequently, physical dependence and tolerance. It will only partially suppress the withdrawal syndrome in individuals physically dependent on morphine or other narcotics. The abuse liability of propoxyphene is qualitatively similar to codeine's although quantitatively less, and propoxyphene should be prescribed with the same degree of caution appropriate to the use of codeine.

USAGE IN AMBULATORY PATIENTS: Propoxyphene may impair the mental and/or physical abilities required for potentially hazardous tasks, e.g. driving a car or operating machinery. Patients should be cautioned accordingly.

USAGE IN PREGNANCY: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. INSTANCES OF WITHDRAWAL SYMPTOMS IN THE NEONATE HAVE BEEN REPORTED FOLLOWING USAGE DURING PREGNANCY. Therefore, propoxyphene should not be used in pregnant women unless, in the judgement of the physician, the potential benefits outweigh the possible hazards.

USAGE IN CHILDREN: Propoxyphene is not recommended for children because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric group.

PRECAUTIONS: Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine. The CNS depressant effect of propoxyphene may be additive with other CNS depressants, including alcohol.

ADVERSE REACTIONS: The most frequent adverse reactions are dizziness, sedation, nausea, and vomiting. These seem more prominent in ambulatory than in nonambulatory patients; some of these reactions may be alleviated if the patient lies down.

Other adverse reactions include constipation, abdominal pain, skin rashes, light-headedness, headache, weakness, euphoria, dysphoria, and minor visual disturbances. The chronic ingestion of propoxyphene in doses over 800 mg per day has caused toxic psychoses and convulsions. Cases of liver dysfunction have been reported.

DRUG INTERACTIONS: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, and other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended (see **Warnings**). Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine.

MANAGEMENT OF OVERDOSAGE: SYMPTOMS. The manifestations of serious overdosage with propoxyphene are similar to those of narcotic overdosage and include respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, pupillary constriction, and circulatory collapse. In addition to these characteristics, which are reversed by narcotic antagonists such as naloxone, there may be other effects. Overdoses of propoxyphene can cause delay of cardiac conduction as well as focal or generalized convulsions, a prominent feature in most cases of severe poisoning. Cardiac arrhythmias and pulmonary edema have occasionally been reported, and apnea, cardiac arrest, and death have occurred.

Symptoms of massive overdosage with acetaminophen may include nausea, vomiting, anorexia, and abdominal pain, beginning shortly after ingestion and lasting for 12 to 24 hours. However, early recognition may be difficult since early symptoms may be mild and nonspecific. Evidence of liver damage is usually delayed. After the initial symptoms, the patient may feel less ill; however, laboratory determinations are likely to show a rapid rise in liver enzymes and bilirubin. In case of serious hepatotoxicity, jaundice, coagulation defects, hypoglycemia, encephalopathy, coma, and death may follow. Renal failure due to tubular necrosis, and myocardiopathy, have also been reported.

Ingestion of 10 grams or more of acetaminophen may produce hepatotoxicity. A 13-gram dose has reportedly been fatal.

TREATMENT: Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation. The narcotic antagonists, naloxone, nalorphine, and levallorphan, are specific antidotes against the respiratory depression produced by propoxyphene. An appropriate dose of one of these antagonists should be administered, preferably IV, simultaneously with efforts at respiratory resuscitation and the antagonist should be repeated as necessary until the patient's condition remains satisfactory. In addition to a narcotic antagonist, the patient may require careful titration with an anticonvulsant to control seizures. Analeptic drugs (e.g. caffeine or amphetamine) should not be used because of their tendency to precipitate convulsions.

Oxygen, IV fluids, vasopressors and other supportive measures should be used as indicated. Gastric lavage may be helpful. Activated charcoal can absorb a significant amount of ingested propoxyphene. Dialysis is of little value in poisoning by propoxyphene alone. Acetaminophen is rapidly absorbed, and efforts to remove the drug from the body should not be delayed. Copious gastric lavage and or induction of emesis may be indicated. Activated charcoal is probably ineffective unless administered almost immediately after acetaminophen ingestion. Neither forced diuresis nor hemodialysis appears to be effective in removing acetaminophen. Since acetaminophen in overdose may have an antidiuretic effect and may produce renal damage, administration of fluids should be carefully monitored to avoid overload. It has been reported that mercaptamine (cysteamine) or other thiol compounds may protect against liver damage if given soon after overdosage (8-10 hours). N-acetylcysteine is under investigation as a less toxic alternative to mercaptamine, which may cause anorexia, nausea, vomiting, and drowsiness. Appropriate literature should be consulted for further information. (JAMA 237:2406-2407, 1977)

Clinical and laboratory evidence of hepatotoxicity may be delayed up to one week. Acetaminophen plasma levels and half-life may be useful in assessing the likelihood of hepatotoxicity. Serial hepatic enzyme determinations are also recommended.

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TODAY'S ISSUES

Florida's New Recovery of Cost Law

W. Harold Parham, D.H.A.
John E. Thrasher, J.D.

Florida physicians were faced with the disastrous loss of medical mediation panels as a result of a decision of the Florida Supreme Court on February 28, 1980, some four years after the same Court upheld the law. The Florida Medical Association, after extensive deliberation, sponsored and endorsed the Recovery of Cost legislation which became law on June 6, 1980. (The effective date of the Law is July 1, 1980 and applies to suits filed in court after that date.)

The loss of medical mediation panels eliminated the only major deterent available to reduce the large number of unwarranted and frivolous medical malpractice suits that were so prevalent prior to the enactment of the mediation statute. The Florida Supreme Court, in striking the mediation statute, found it to be "intractably and incurably defective." This strong and unprecedented language dealt the statute a fatal blow and made it mandatory to look to other mechanisms that would accomplish the purpose and intent of the mediation law.

The recovery of cost concept was the recommended approach. This law provides.

— The losing party (except those who are insolvent or poverty stricken) is to pay the attorneys' fees of the prevailing party in a malpractice action, and

— The attorney is to advise his client in writing of the provisions of the law before initiating a Suit, and

— A party to make an offer to allow judgment to be taken against him and such party shall not be taxed for the prevailing parties' attorneys' fees which accrue subsequent to such offer if the final judgment is not more favorable to the prevailing party than the offer.

Originally, the concept (as introduced by prime sponsors, Representative Barry Kutun and Senator Dick Anderson), was to apply to all civil actions. The original bill was intended to amend Section 57.105, Florida Statutes, which provided for a court to award a reasonable attorney fee to the prevailing party in any civil action where it is found that there was a complete absence of a legal or factual issue raised by the losing party. Unfortunately, this law was applied by judges in only rare circumstances, and therefore is ineffective in curtailing non-meritorious suits.

In limiting the concept to medical malpractice cases, the Legislature went far to explain its reasoning and rationale for treating this kind of civil lawsuit differently from others. Indeed, it is not unique for the Legislature to single out a particular class of litigation and treat it differently. One only needs to look at the laws relating to workers compensation, no fault automobile, no fault divorce, etc. It is anticipated that the extensive legislative findings adopted by both the House and the Senate will be highly persuasive to a court if the constitutionality of the Act is challenged.

The substance of the legislative findings, or "whereas clauses" strongly support the arguments made by the Florida Medical Association in support of this legislation.

Essentially, the Legislature, through its committee hearing process, found the following:

— In 1975 it had addressed the malpractice crisis and attempted to solve it (e.g. frivolous malpractice suits and prohibitive insurance costs), primarily through the enactment of

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the mediation statute. The mediation system worked well, as is evidenced by the following whereas clause:

"The date from the period in which Mediation Panels were in operation indicates they provided an efficient and effective mechanism for screening out non-meritorious claims and for encouraging prompt settlement of those claims with merit."

— The effect of the invalidity of the Mediation Statute and the removal of its proven positive results would bring about a marked destabilization of the professional liability insurance marketplace and a traumatic increase in professional liability insurance premiums paid by health care providers in Florida, thus precipitating another crisis in the professional liability insurance market.

— An alternative to mediation panels was desperately needed to similarly screen out claims lacking in merit and enhance the prompt settlement of meritorious claims.

— Alternative is the "English Rule" of Costs which requires the loser in litigation to bear the reasonable legal cost of the winner.

The principal effects of this Law can be summarized as follows:

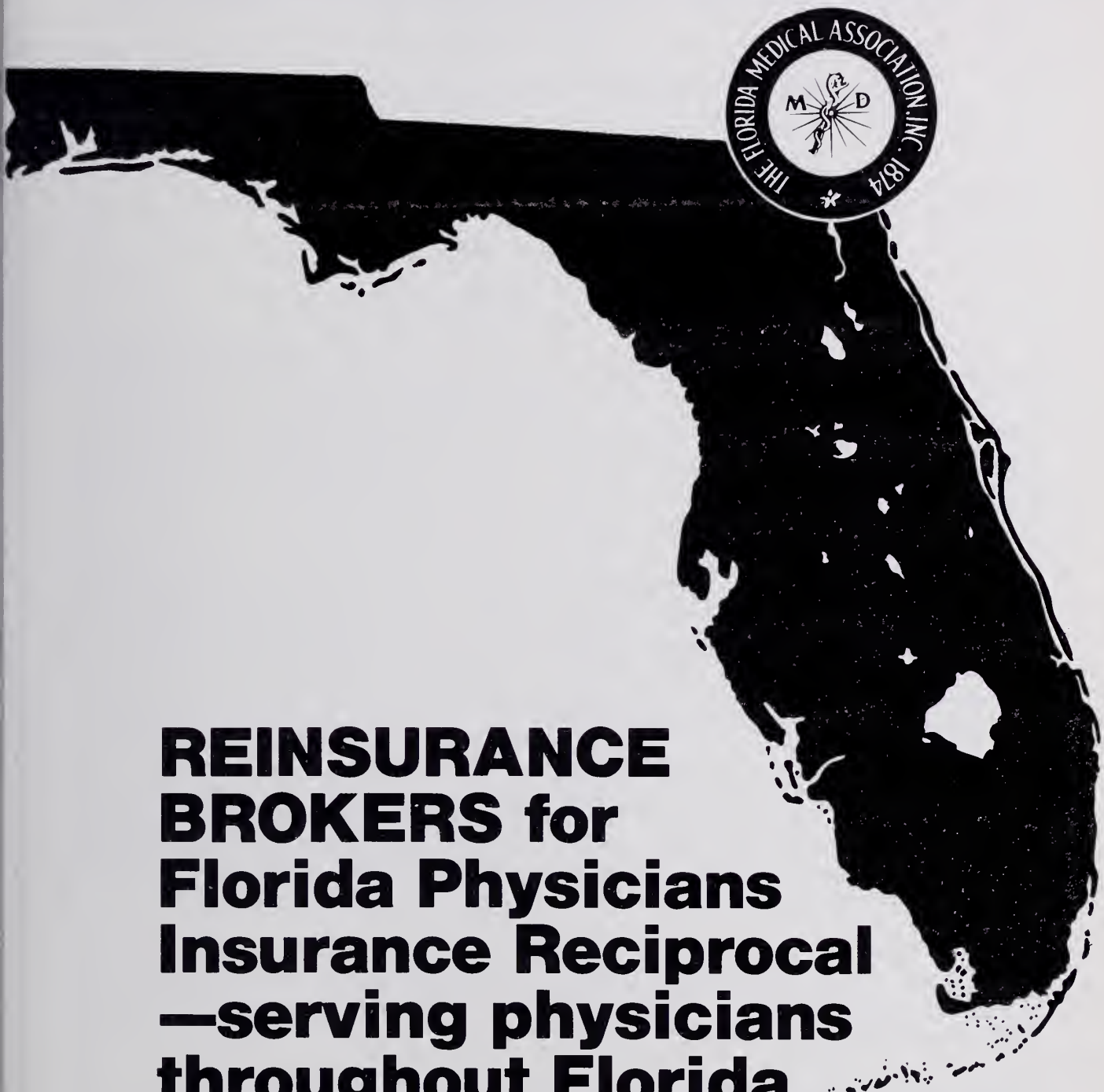
a) The number of nonmeritorious suits will be reduced. Attorneys will be required to more carefully scrutinize a case before advising their client as to the merits. The Law *requires* the attorney to advise his client, in writing, of the provisions of this Law before initiating a suit.

b) Once a suit is filed, the merits of the suit will continue to be determinative of the willingness of the parties to press forward. Accordingly, settlement, where appropriate, should be hastened. Additionally, there is a provision of the Law that allows a party to make an offer to allow judgment to be taken against him. Should this offer not be accepted and the jury returns a verdict less than the offer, the attorney's fees which accrue subsequent to the offer would not be taxed against the losing party. Here again, the evaluation of the merits of the case, becomes increasingly important.

This concept and the intending results from the Law have been hotly debated. The most common criticism from attorneys representing claimants is that the Law will have a "chilling effect" on access to the courts. This is simply not true. The Law will not discourage legitimate claims that have been reviewed and researched by the attorney and a fair-minded medical expert. Moreover, as a matter of public policy, it is not unjust to require the losing party to make the winner whole. The winner in a lawsuit loses when he wins because he must bear his own costs in defending the lawsuit. One is logically forced to ask why the winner should be required to bear his own legal fees when the loser put him to great expense. The loser may have been free of malice or have had reasonable cause to believe his case was sound; yet, the winner was correct in his assessment of the case's merits.

The enactment of this legislation represents the continued desire of the Florida Legislature to again stabilize the medical liability field and to prevent a return to the 1975 crisis situation. Even with the mediation statute, reports and projections of claims indicated serious problems and potential staggering premium increases. Indeed, without the enactment of the Recovery of Cost Law, we could have anticipated grave consequences in the cost factor of medical liability insurance.

The responsible action of the Florida Legislature, motivated by its continued desire to ensure a stabilized environment in which physicians can practice medicine, has averted another crisis. The passage of this legislation would not have been possible without the strong and dedicated support of the officers and individual members of the Florida Medical Association, their wives and the FMA staff and consultants.



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September 4 - 5, 1980

The Hilton Inn — Gainesville, Florida

Director: Howard W. Ramsey, M.D.
Co-Directors: Luis J. Cintado, M.D.
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The sixth symposium is devoted primarily to a review and reappraisal of past and current concepts of diagnosis and treatment of cardiac disease. Topics that will be discussed during this year's symposium include: medical and surgical treatment of coronary artery disease, current status of prosthetic cardiac valves, coronary angioplasty, coronary artery spasm, nuclear cardiology and two-dimensional echocardiography.

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Approval for appropriate credit hours has been requested from the Medical Education Committee of the Florida Medical Foundation, the Florida Academy of Family Physicians, the American Society of Radiologic Technologists and Nuclear Technologists, and the National Society of Pulmonary Technologists.

HOTEL RESERVATIONS: A block of rooms has been reserved at the Hilton Inn for symposium participants and reservations can be made through your local Hilton Inn, the Hilton Reservation Service (toll free number listed in your local telephone directory) or by calling the Gainesville Hilton directly (AC-904) 377-4000.

RESERVATION FEES: $200.00 — All physicians
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Historical Issue

William M. Straight, M.D.
Historical Editor

IN THIS ISSUE . . .

Within the covers of this Historical Issue are three articles of interest to Florida medical history students.

First is an article by Dr. Frederick Eberson of St. Petersburg, on the drive to eradicate hookworm disease in our state. This disease was a great public health problem not only in Florida but throughout the South during the eighteenth and early nineteenth centuries. The Florida State Board of Health was the first agency in the nation to launch an eradication program. Dr. Eberson brings this to us with a perspective of many years of public health work, both at the university and the community levels, and a publishing experience that includes six books and over 100 journal articles.

Second is an account of bloodletting written by Dr. Paul J. Schmidt, Director of the Southwest Florida Blood Bank and Dr. James E. Changus, Department of Pathology of the St. Joseph's Hospital, Tampa. Bloodletting, an ancient therapeutic method of the Western world, was practiced by the Florida Indians even before the Spanish arrived in our state. The custom fell into disuse as a therapy during the latter half of the nineteenth century but it has been enthusiastically reborn as a diagnostic procedure in our time.

Finally, for the Civil War buff there is an article by the Historical Editor on medicine in Florida and with the Florida troops during the War Between the States. Florida supplied about 10 percent of its population as soldiers and perhaps 50 percent of its physicians to the Confederate States Army. From the meager records which have survived those times the author has attempted to sketch the life and times of the wounded Florida soldiers and of the physicians who attended them.

William M. Straight, M.D.
Historical Editor

Eradication of Hookworm Disease in Florida

Frederick Eberson, M.D.

Hookworm disease was recognized under various names in the tropics as early as the seventeenth century. When first described in the mid-nineteenth century the worms were given the name Ankylostoma, from the bent or curved appearance of the mouth. At about the same time investigators in Germany identified the parasite as the cause of the distinctive anemia and dropsy that make up the picture of hookworm disease. In Italy during the "seventies and eightys" of the last century the anemia of miners, tunnel diggers and brick workers was shown to be caused by this parasite.

As to the occurrence of the disease in the United States only occasional reference was made prior to this century. Not until the extensive investigations of Stiles[1,2] was hookworm shown to be widely prevalent, especially in the southern states. Only then was it recognized that hookworm was responsible for a vast amount of illness and anemia and was linked directly with the traditional dirt eating practice.

Mode of Infection

In 1898 the devious path of the hookworm parasite was described by Arthur Looss. He showed experimentally that the larvae penetrated the skin, were carried by the veins to the heart and thence to the lungs. From there they escaped through the pulmonary vessels into the bronchi and up the trachea to the throat and were swallowed finally lodging in the intestines.[3] He further showed that enormous numbers of eggs, sometimes in the millions, were passed with the stool of infected persons and were incubated in the moderately high temperatures of the feces mixed with warm earth. After four or five days the larvae became infective and penetrated the skin causing a visible local irritation. This so-called ground itch has been observed in over ninety percent of the cases.[4] Soil pollution in tropical and subtropical regions easily explains why bare feet are an open invitation to the bloodthirsty parasite. Its victims are undernourished, hungry and can ill afford the luxury of the sole preventive, the wearing of shoes.

In this connection one's thoughts might wander to the middle of the nineteenth century when the famous poet, John Greenleaf Whittier, wrote these words, "Blessings on the little man, barefoot boy with cheek of tan . . ."[5] an idyllic New England picture of youth glowing with health in the summer sunshine, enjoying the caressing touch of cool, soft grass underfoot. However, unlike his counterpart in the southern states, this New England lad went barefooted by choice, not of necessity. He knew nothing of the deprivations of poverty, hunger and filthy surroundings where the polluted soil was infected with hookworms ready to invade the victim's body by piercing the under surface of the feet.

Probably one of the earliest references to suspected hookworm disease in the south is contained in a report from Gadsden County in the northern part of Middle Florida. "Apart from the sickening influence of malaria, we cannot refrain from noticing the degeneration, mental and physical, of children reared in this extreme southern part of the Union. During our first month's residence in Florida in passing through the country we often stopped boys in the road, not over ten or twelve years of age, who presented the most abject state of degeneration imaginable; with head and body large, limbs shriveled and deformed, eyes dull and of bilious tinge, lips colorless and features distorted. This degeneration, by many, has been attributed to dirt eating, a propensity very general throughout the whole country."[4,6]

Dirt eating is a form of pica and a sign of anemia due to iron deficiency. The tendency has been commonly observed in hookworm disease thus giving credence to its diagnostic role. Osler also mentions, ". . . the remarkable perversion of appetite in severe cases; the patient eats earth, clay, chalk, paper, starch and hair. The dirt eaters of the southern states are all subject to hookworm disease."[8]

The Campaign Against Hookworm in Florida

The early development of organized public health in Florida is linked with the name of Doctor Joseph Yates Porter, the first state health officer.[9] He took office in 1889 and served seven terms of four years each. Under his able leadership were created separate bureaus with specific responsibilities, the groundwork of the present organization of public health in this state.

The turn of the century marked a period of great activity in the field of public health, particularly in the epidemiology of smallpox, yellow fever and malaria.

The Author

FREDERICK EBERSON, M.D.

Dr. Eberson is retired from the practice of general preventive medicine in St. Petersburg.



(Courtesy of Dr. Wilson T. Sowder)

These were the big three and other infectious diseases received little attention. Significantly hookworm disease, water purification and sewage disposal were not part of the public health picture. There was the ever present problem of limited and meager appropriations by the legislature. Considering the amount of money available each year for general programs with some additional amounts for extraordinary expenses, such as for control of epidemics, the achievements of Florida's first health officer were all the more remarkable.

Efforts by the State Board of Health to control hookworm disease were initiated in January 1903. At this time Doctors William P. Adamson and John S. Helms of Tampa began to observe the disease in that part of the state. Dr. Adamson brought this to the attention of Dr. Hiram Byrd, Assistant State Health Officer and Field Representative of the State Board of Health. Only then was hookworm disease recognized as a public health problem.

Five years later an aggressive campaign against hookworm was launched by the board of health. The project began with a meeting of the Florida State Teachers Association in Gainesville. All teachers were placed on the mailing list for the monthly bulletin, *Florida Health Notes*, informed of the symptoms of the disease and urged to help uncover cases. Widespread interest throughout the state resulted in the discovery of many new cases.

The principal feature of this program was an agreement by the State Board of Health to pay physicians in private practice three dollars for treating each indigent patient with hookworm disease provided that laboratory confirmation was made and a report of the patient filed. The recommended therapy at that time was, "a few drops of thymol repeated at intervals of about two weeks until parasites are no longer present in the feces." Thirty years later (1938) at the time *The Story of Florida* by W. T. Cash was published[10] Chenopodium and carbon tetrachloride were used more often than thymol. It is interesting to note that both Chenopodium and thymol are plant derivatives, pointing to the value of herbs and useful medicaments. Another feature of the program was two physicians placed in the field to reach and instruct the nonreading population. However only some years later was vigorous attention given to improvement of environmental sanitation.

Taylor County followed up a successful mosquito control campaign with an attack on hookworm disease. Aided by the State Board of Health the county officials started a hookworm eradication program which received exceptionally good cooperation from the citizens. In the two years of its operation 544 sanitary privies were constructed and a comprehensive educational program was carried out. A survey made before the program showed sixty percent of the population had hookworm ova in their stools whereas a comparable study two years later revealed only forty-six and six-tenths percent had stools containing the ova.

In justifying the amount of money being spent on this program, Dr. Porter pointed out that, "For every three dollars spent a little hookworm sufferer will be redeemed from the tortures of living death." This program of education, laboratory diagnosis and treatment continued with variations in emphasis throughout the remainder of Dr. Porter's tenure.[11]

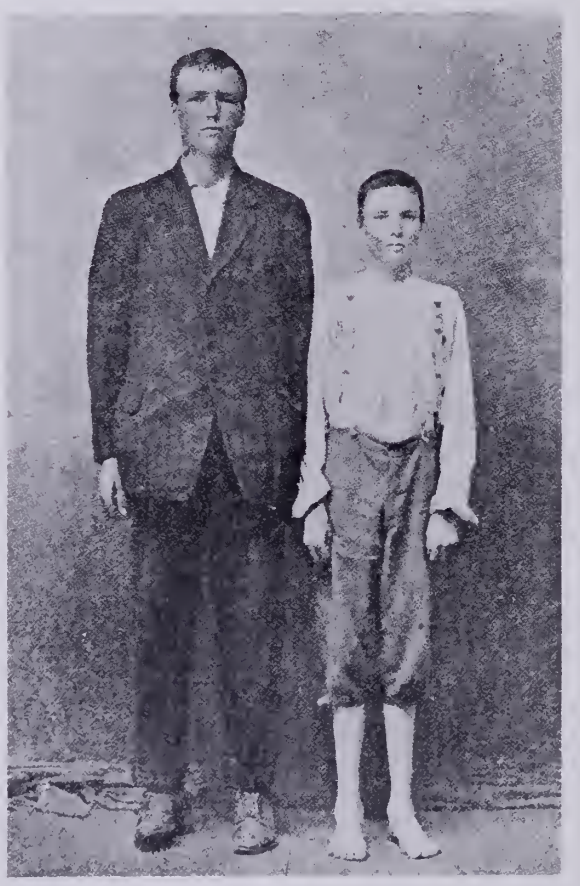
It should be noted that Florida set up this campaign to eradicate hookworm prior to the formation of the Rockefeller Sanitary Commission. Responding to Dr. Porter's invitation the administrative secretary of that commission and many state directors of sanitation visited Florida to study the methods and results of Florida's effort. The first report of the Rockefeller Commission acknowledges its indebtedness to Dr. Porter and his staff and in its appendix carries a summary of the Florida work from October 12, 1909, to December 31, 1910.[12]

During the above period the state health officer and three assistants covered 6,220 miles by railroad, 1,070 miles by horse and buggy or wagon, and 330 miles by

boat for a total of 7,620 miles covered. The total cost amounted to $8,737.45. Included in this limited budget is the cost of stool examinations at a central laboratory in Jacksonville and at two satellite laboratories, one at Tampa and one at Pensacola. These laboratories examined 7,243 stool specimens of which 4,454 (61.5%) were positive for hookworm ova.

Results of the Campaign

During 1910 five hundred sixty-two physicians from 197 towns and forty-seven counties who submitted specimens to the state laboratories are believed to have treated 20,000 patients. Of these it is thought about 60% were suffering from hookworm disease. It is thought that about 500 other physicians within the state treated hookworm although they had not submitted specimens to the laboratories. A report at the time concludes: "At the present time it is believed there is hardly a physician in the state not treating the disease (hookworm); a belief based upon the fact that none such has been found for the last several months by a corps of four or five physicians who have been covering the state in all directions."[12]



Effect of Hookworm on Growth — Brothers aged 17 (L) and 18 (R); without hookworm (L) and with hookworm (R). (Courtesy: National Library of Medicine)

Hookworm Disease Among the Seminoles

Control of hookworm disease among the Seminole Indians was one of the outstanding achievements during this period. Several visits were made to the Episcopal Mission at Everglades City and the camps in the Everglades. These revealed the presence of severe hookworm disease in a large number of Indians. At Immokalee, a town about midway between Fort Myers and the mission, conditions were typical of the entire area. Infestation was as high as 100% in some families and the soil surrounding their habitations was teeming with organisms. Launch trips along the coast and up the Caloosahatchee River showed the disease was more frequent inland than along the banks of the coast or river. This seemed most likely due to the nature of the soil.

Obstacles in Treatment

Although it was thought that a large percentage of the treated cases were cured by the treatment then available, valid follow-up statistics were hard to gather. Often patients would not submit a follow-up stool specimen and when the patient was a child even an appeal to the parents frequently failed. This was especially true among the rural population where disinterest and distrust seemed most prevalent. The marked symptomatic improvement that often followed the initial treatment was frequently interpreted by the child and parent as a cure reinforcing their wishful thinking that no more medication was necessary. A second obstacle was posed by families who brought the severely infected children in for treatment while leaving the mildly to moderately infected ones at home. These later, of course, served to reinfect their siblings by spreading abroad stool discharges containing the hookworm ova.

Some of these problems are colorfully described by Dr. James M. Anderson who practiced at Mayo beginning in 1910. His diary, from which the following quotation was taken, appears in the August 1974 issue of *The Journal of the Florida Medical Association.*

> "During the first few weeks I was of very little help to Dr. (O.F.) Green and had plenty of time to seek out children that I believed had hookworms and urge parents to bring me specimens to the office. I would where possible insist that the parent that brought the specimen stay with me until I had located the eggs. First with the low power on (the) microscope and let them have a look at the numerous eggs we found. Then I would locate a single egg and turn on the second power of (the) microscope and with good light this would show the shell of (the) egg and interior as well . . . Convincing the parents was comparatively easy but the treatment in those days realy did have its hazards. Thymol and betanapthol were the only two remidies known at that time. You had to starve them both before and after treatment. We would often run into fierce opposition from parents on this account. I remember one quite amusing incident

along this line. I had discovered five children in one family that had the worms. I prescribed the treatment and so far as I know the mother gave it religiously as directed and admitted each child past quite a quantity of worms, but when she sent in another specimen the children still had worms. The mother weighed about 250 lbs. . . . when I told her the children would have to take another treatment to get rid of worms, she rebelled. Giving as her reason that she simply could not eat on days that she starved the children and she was just not going to undergo another day of starvation like she did when she gave them the first treatment . . .

"When we would cure a case of hookworm disease and instruct mothers to make their children wear shoes until the dew or rain had dried off the grass, not one mother out of four would see they obeyed these rules. So three out of every four children that we cured of this disease would have it again within a year after we had cured them."

Added to these difficulties were the obtuse, illiterate and contrary people who rebelled at school inspections and treatment of hookworm suspects; indeed, many were inclined to laugh at the idea. In one family with six suspected cases the parents objected on religious grounds and, "would allow no medicines to be given to their children."[11]

Although Florida was the first in the United States to initiate a vigorous hookworm eradication effort, toward the end of Dr. Porter's tenure in office hookworm disease remained a major public health problem. During the years 1908 to 1914 an intense educational campaign on hookworm disease prevention had been carried on and large numbers of school children had been screened but the problem remained. It gradually became evident that the state board of health policy of free treatment of any hookworm sufferer was encouraging rural families to ignore the preventive measures the educational program advocated. Thus patients who had been successfully treated became reinfected and returned for a second or third treatment. Therefore free treatment was curtailed and most of the discovered cases were referred to private physicians for therapy.[11]

HOOKWORMS

What the Worms Do

They stay in the intestines and suck blood.
They inject a poison into the circulation.
They turn loose in one place and take hold in another.
They lay eggs by the thousand to be passed out in the stools.

GROUND-ITCH

How It Is Gotten

By going barefoot or wearing leaky shoes on damp ground that has been polluted by hookworm sufferers An abrasion of the skin is not necessary. It may also be contracted about cow lots.

How to Keep From Getting It

Don't go barefoot or wear leaky shoes

How to Keep It From Spreading

Cure all hookworm sufferers.
Stop soil pollution.

READ THIS AND PASS IT ON TO YOUR NEIGHBOR

Educational Leaflet — (Annual Report, Florida State Board of Health, 1908-1909)

New Plan of Studying the Effects of Hookworm Disease

About this time a decreasing number of stool examinations for parasites appeared, indicating public apathy toward this health problem. The people of Florida needed to be aroused from their lethargy. To do this the board conceived a program that would gather data for a careful look at the effect of hookworm disease on the mental performance of children. Under this plan the district assistant to the state health officer selected one urban and one rural school in his district. Stool specimens from each pupil in these schools were examined for hookworms and clinical examinations were made to evaluate the severity of infection in each case discovered. These data were tabulated to show the total number of children examined, the number free of worms and the numbers of children mildly and severely infected. This statewide study provided the beginning of a valuable comparative study of the prevalence of hookworm disease in communities with and without adequate sewerage facilities and of the effect of the disease on children's scholastic performance.

A Nurse's Shrewd Observation

In 1917 because of a reduced legislative appropriation the State Board of Health was forced to curtail its services and staff. One victim of this action was the promising district nursing service which had been very

active in the hookworm eradication program. Some of the counties countered the loss of service by appointing county nurses to work in the schools. Thus in 1918 the first county nurse was appointed in Pinellas County.[14] In 1922 a survey in the Pinellas school revealed an incidence of hookworm in as high as fifty-two percent of the children examined. A program was begun in which the county school nurses traveled to the childrens' homes over the wide area of the county collecting stool specimens. All children found to have the parasites were urged to obtain treatment from their local physician. Families were bombarded with educational material and urged to install sanitary privies and clean up their surroundings. In the course of this campaign a shrewd nurse observed that hookworm infestation in the schools varied with the kind of school population. In one school for white children only, one-third had the disease, while in the schools attended by black children only, hookworm disease was rarely found despite the poorer sanitary conditions in the districts populated by blacks. Since it was not a matter of putting shoes on the feet of all persons exposed to soil infestation with the larval parasite, or improving their hygiene and sanitation, another explanation seemed necessary.

Taking all these factors into account, it appeared the black race might be less susceptible to this disease. In the hope of getting some information on the subject, a letter of inquiry was sent to the state health officer who located a reference to a "world authority on the subject of hookworm disease."[16] Summarizing this article it appears that in Africa a high infection rate with relatively little disease occurs, but in the United States, blacks living under the same sanitary conditions as whites usually show no evidence of hookworm disease and a much lower infection rate. It seems probable that over the centuries some biological selection has occurred in Africa. Moreover, in the southern states there is a consistent difference in physical appearance between the rural blacks and their economic counterparts, the white sharecroppers, who may or may not have hookworm. Again this suggests that the underlying mechanism of difference in racial susceptibility or immunity is not known.

By common report there is probably no widespread human infection of equal significance to mankind which is less self-assertive than hookworm. Beginning in early childhood and developing gradually the effects produced are easily overlooked. A great majority of these infestations are not severe enough to produce obvious symptoms under otherwise favorable conditions. Handed down from generation to generation over long periods of time, the cumulative effects of the disease on the race are more important than mortality statistics. Where the infection is virtually unlimited, this disease may well explain the visible retardation of backward peoples.



Barefoot Children Infested with Hookworm[11]

"The lazy blacks" and the "poor white trash" of the South were found to be unsuspecting victims of an insidious disease which sapped their vitality and stunted their development . . . they deserved pity and sympathy rather than contempt and derision from the more fortunate in unaffected localities.[15]

During the years 1923 through 1933, Florida experienced a boom and a bust. Early in this period the population grew rapidly but with the bust the growth did not cease although it slowed. The growing population resulted in increasing need of public health services but the money needed was hard to come by. Finally, with the advent of the Federal Emergency Relief Administration in 1934, federal funds were suddenly available to hire 275 county health nurses. These nurses rejuvenated the lagging communicable disease program including the hookworm eradication effort. Under their prodding the

construction of sanitary privies for rural homes became a major project. Furthermore funds became available that permitted small towns to construct water purification and distribution systems and sewage disposal systems.

Studies conducted at this time revealed a hookworm infection rate of fifty to eighty percent of the school children. In a one teacher school with nineteen pupils 100% of the children had hookworm. Even though experts on this disease urge a distinction between infestation and disease, both are of great importance from the view of the sanitarian. It has been reported[17] that a person may carry 30 to 40 worms without showing physical signs of the disease. Yet one female worm can deposit as many as 9,000 eggs in twenty-four hours; a potential soil pollution of 360,000 larvae daily from each carrier. An estimate of the potential from a person with active hookworm disease would give astronomical numbers of parasites. These statistics graphically illustrate the importance of isolating infective stools in properly constructed privy vaults.

The momentum generated by the several relief agencies with the newly created acronyms, FERA, WPA, etc., was sustained and Florida's public health programs made great strides. To help in an impartial evaluation of problems and solutions the State Board of Health and other cooperating agencies requested the American Public Health Association to send a team of consultants to study Florida's health programs and recommend improvements. The report of this team, published in 1939, emphasized the need for control of malaria and hookworm disease, the two diseases which had so constantly plagued the state's public health workers. In fifty-six of the sixty-seven counties studied, three had an incidence of over seventy percent with hookworm in the rural white population. The remaining fifty-three counties showed an incidence varying down to slightly over seven percent.

Another study of hookworm disease in Florida that was published in 1939[19] was of an investigation conducted by a Vanderbilt University team during the period 1937-1938. Cooperating in this study were the Florida State Board of Health, and the International Health Division and the Division of Medical Sciences of the Rockefeller Foundation. This study was the most sophisticated statewide study of the subject yet attempted.

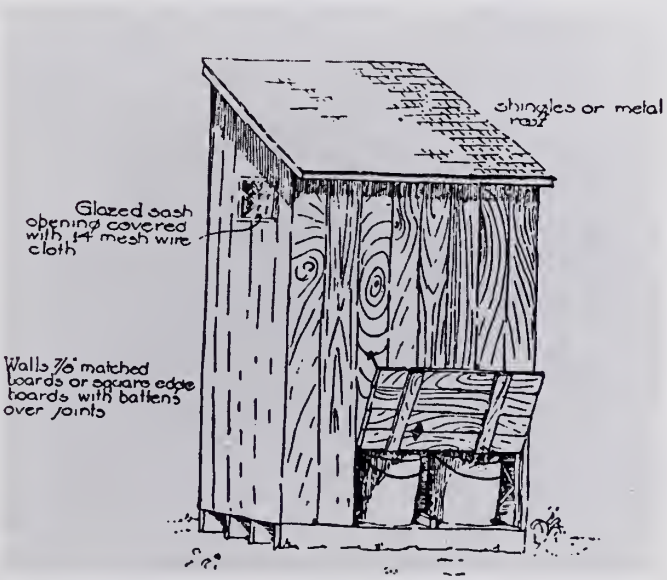
In this study 29,064 persons in 543 rural communities of fifty-six counties were examined and thirty-five percent found to have hookworms. In the panhandle the incidence was 49.2%, in the northeast, 38%, in central Florida, 25.2%, and in the nine southern counties 23.2%.

The greatest incidence was in school children with the peak incidence in the 15 to 19 year old group (44.7%). In adults the incidence was about half that in children and in both groups females showed a higher incidence than males. Stool specimens from 4,121 black persons living in 64 communities of 26 of the counties were also examined. Of these 19.9% were positive for hookworm, about half the incidence found in the whites. The age distribution was essentially the same in blacks as in whites. However, the worm burden sufficient to produce clinical symptoms was three times greater in whites than in blacks.

Analysis of infections by household groups revealed striking evidence of the effect, extent and rapidity of dissemination of the disease. In over 6,000 household groups in which two or more members were examined, 58.8% showed one or more infected members. As the number of members in the group increased, so did the average intensity of the infection. For example, an average burden of 2,100 eggs per cubic centimeter of feces equalled 84 worms per person, if a single person of the group was infected. This increased to 8,800 eggs per cubic centimeter of feces, or approximately 352 worms if six or more members of the group were infected.

Nearly forty years after the first intensive study of hookworm disease in Florida it was still considered the foremost parasitic problem.[20] Here the hookworm found the three requisites for unbounded propagation: favorable temperatures throughout the year, abundant rainfall and sandy, well-drained soil. Another helpful environmental factor was areas in which a large part of the rural population lived under poor economic conditions which encouraged both a high incidence and a high intensity of infection.

In 1947, when times had been more prosperous for some years, a study was made to find out if the improved economic conditions had materially reduced hookworm



Sanitary Privy — (Courtesy: National Library of Medicine)

infection throughout the state.[20] Although nearly 40% of the white children examined were found to have hookworm, in less than 4% was the worm burden of sufficient intensity to classify them in the moderate or heavy categories. This means that less than 4% had clinically significant disease as compared to the 11.5% in the 1937-1938 survey. This substanial reduction of both infection and intensity was accomplished through improved sanitation and the treatment of many individuals. However, the hookworm is not entirely gone for it would seem that, like our more welcome winter visitors and tourists, it prefers the Florida climate as later reports indicate.[21-24]

In 1951 a survey primarily directed at the relationship between hookworm and anemia turned up hookworm in 33% of 3,881 persons examined. Another study in 1952 of over 10,000 school children showed 33% infected with hookworm and in still a third survey in 1953 of 22,816 persons 30.8% had hookworms in their stools. In this last study both hookworm and anemia were present in 27.4% of the school population.

The Progress of Hookworm Eradication in Florida

A review of the public health statistical reports shows a decline in the incidence and severity of hookworm disease in Florida over the years. In 1950 there were just over 10,000 cases; in 1957, 2,197 cases; in 1960, 3,260 cases; and in 1964, 1,726 cases.[25]

At a conference on communicable disease in St. Petersburg in the spring of 1972, a panel was devoted to intestinal parasites and hookworm in particular. It was implied that the hookworm scourge had been eradicated but only vigilance will prevent its return.

The Summing Up

Modern medicine, preventive as well as curative, must consider the community rather than the individual as a patient. This concept involves socioeconomic and environmental conditions of the malnourished, underprivileged, poorly housed and poorly educated as well as politics. This new concept which reaches out to the people and emphasizes preservation of health rather than the treatment of disease, had been integrated into our social structure and fortified in recent years by an enormous amount of health legislation.[27,28]

As to hookworm disease in Florida, unprecedented improvements in sanitation, housing conditions and the education of the public in the simple principles of disease prevention, have played a major part in stemming the spread of the disease. With their economic status vastly improved, undernourishment among the poorer classes of whites and blacks is not so prevalent as in previous years, and today, despite the rising costs, shoes are worn by those who formerly went barefooted in their hookworm-infested home surroundings.

Perhaps our story can end appropriately with the words of a bespectacled American philosopher of the eighteenth century: "An ounce of prevention is worth a pound of cure."

Acknowledgements

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The Bloodletters of Florida

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In Florida, as elsewhere, there are modern usages of technically sophisticated therapeutic bloodletting with an occasional throwback to more primitive times.

The most interesting period of phlebotomy in Florida may well have been the earliest colonial days. In that era, the bleeding customs of Caribbean Indian tribes were practiced side-by-side with the skills of European ship surgeons. The contrasting features of those medical traditions are uniquely illustrated by the experience of one Lionel Wafer.

Indians and Colonists

In 1681, Lionel Wafer, a young English physician, was marooned on the Isthmus of Darien. He had learned his profession while very young "in the service of the surgeon of the ship," probably on pirate vessels. He had also several years of practice in Jamaica, "at Port Royal where I followed my business of Surgery."

On his third voyage, he was left behind with "the wild Indians" to recuperate. His book on that experience contains many medical observations on the New World.[1] Among the most descriptive passages are those telling of his life with a Panamanian Indian tribe whose chief, Lacenta, was "Prince over all the South."

> "It so happen'd, that one of Lacenta's Wives being indisposed, was to be let Blood; which the Indians perform in this manner: The Patient is seated on a Stone in the River, and one with a small Bow shoots little Arrows into the naked Body of the Patient, up and down; shooting them as fast as he can, and not missing any part. But the Arrows are gaged, so that they penetrate no farther than we generally thrust our Lancets: And if by chance they hit a Vein which is full of Wind, and the Blood spurts out a little, they will leap and skip about, shewing many Antick Gestures, by way of rejoycing and triumph."

Wafer offered to perform the "Business of Surgery" in a better way and with his lancet "breathed" Lacenta's wife's vein. There was the sudden appearance of a stream



Fig. 1. — Bloodletting by the American Indian. (From Lionel Wafer, A New Voyage and Description of the Isthmus of America, 1699. National Library of Medicine).

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Fig. 2 — North Florida. Blood sucked from the patient's skin is then drunk by a pregnant woman. LeMoyne 1564 (From Charles E. Bennett. Settlement of Florida. U. of Florida Presses).

of blood, and "Lacenta swore by his Tooth, that if she did otherwise than well, he would have my Heart's Blood."

Only 12 ounces were taken and the patient was well the next day. Wafer was made much of by Lacenta in a speech and after that he was carried from tribe to tribe in a hammock "in great Splendor and Repute, administring both Physick and Phlebotomy to those that wanted."

It is not likely that Wafer had read of the circulation as described by Harvey 50 years earlier. But of course, bleeding had been the job of the barber surgeons from earliest times. Henry VIII had granted a charter in 1541 to his chief surgeon, Thomas Vicary, the elected Master of the United Company of Barbers and of Surgeons.

Wafer specifically could cut or "breathe" a vein, whereas the American Indian just cut indiscriminately, albeit to a regular "gaged" depth. To what extent was Lacenta's method of bloodletting practiced by the Indians of Florida? The Calusas of South Florida were skilled seafarers and it is possible that they had come from the islands of the Caribbean to make a new home in Florida long before the coming of the white man.[2] They would have brought their knowledge of medicine with them.

Already in 1564, a century before Wafer, French Huguenots had planted the first European Colony this side of Mexico near the mouth of the Saint Johns River in Northeast Florida. In the engravings of Le Moyne, he illustrated bloodletting for pain by the Timucuan Indians who cut the skin with a sharp shell and then sucked out blood.[3] Rather than waste it, that blood was given to drink to women who were nursing or pregnant. Much later, Bartram describes the use by Florida's 18th century Indians of the sharp teeth of the garfish to scratch and bleed themselves.[4] Those references tell us that the practice of bleeding by the Indians of Northern Florida was much more primitive than that of the Indians of Panama. There was an official position of *sangrador barbero* (phlebotomist barber) on the rolls of the St. Augustine garrison in 1749.[5]

The Armamentarium

Many of the instruments used for venesection by European surgeons of Wafer's day, and earlier, became the tools of Florida's colonial physicians. In an important sense the available tools molded the history of practice. For an appreciation of the depth of such practice, one needs to look at a truly encyclopedic German manual documenting a 600 year history of surgical instruments which was published in 1838. It illustrates 69 varieties of bleeding instruments and describes them in 45 pages of text.[6]

The instruments are classified as being of five types: the Lancet, the Fleam and the Schnapper were for opening an artery or vein; the Scarificator and the Cup were for collecting capillary blood. There were also special instruments for applying the leech.

The Lancet—The true lancet was described over five hundred years ago. It had a flexible, pointed blade, usually double-edged and with folding guards of tortoise shell. Closed it was only 1½ to 2 inches long. It was of course such a universal instrument in the medical practice that its name was given in 1823 to the most prestigious medical journal of the day.
The Fleam—The fleam usually had three triangular blades which folded into a brass or bone case.
The Schnapper—The spring lancet invented in 1680,[7] had a single blade which was springloaded. It was made of steel or brass and was packaged in a small, fitted leather case. It became popular because its use required little knowledge of anatomy, and less bravery than the fleam.
The Scarificator—Ambrose Pare is credited with introducing the name in the 16th century[8] for the



Fig. 3 — The Physician's tools: Fleam, Scarificators and Cups. (Property of Dr. G. C. Austin, Miami. Photograph by Charles Bailey, U. Miami Department of Medical Photography).

brass box containing a strong spring which drove a set of razor-sharp blades. The cutting depth was adjustable.

The Cup—Dry cupping was done by placing a dome-shaped glass on the skin. The cup was heated to produce a vacuum although some models connected to a stopcock and syringe. In wet cupping, the glass was applied after the scarificator or the lancet had made multiple superficial cuts in the skin.

The Leech—Feeding the leech to engorgement has been a method used from antiquity to the present day. One of the theses submitted for the degree of Doctor of Medicine from the University of Basel as late as 1949 was entitled: "On the leech and its use in medicine."[9] The leech jar was once a classic piece of pharmacist's pottery. The animal had to be handled carefully and among the instruments described was a speculum for placing the leech in the vagina.[6]

The Nineteenth Century

Among American physicians who brought the tradition of bloodletting to this country from their European training was Benjamin Rush, the "Prince of Bleeders". That signer of the Declaration of Independence, Physician-General of the Military Hospitals of the United States, first American psychiatrist and founder of Dickinson College, believed with a passion in the value of bloodletting, especially in the treatment of yellow fever and mental illness. In a career as medical educator he taught more than 3,000 students, and he taught them all how to bleed, and bleed, and bleed again. "If the state of the pulse be our guide, the continuation of its inflammatory action after the loss of even 100 ounces of blood, indicates the necessity of more bleeding." One of Rush's patients lost 470 ounces (14 liters) in forty-seven bleedings.[10]

As a teacher, Rush had a great influence on medicine in the South. Of the 116 physicians who had become members of the Medical Society of South Carolina up to 1813, the year of his death, 60 were pupils of Rush. One of them, William Montgomery, writing to Rush described his treatment of a member of the South Carolina legislature in 1797 by saying that he, "took from him 165 ounces in five days without affecting his pulse or diminishing his fever. He died. Had we taken a still greater quantity the event might perhaps have been more fortunate."[11]

More of Florida's early physicians were trained in the medical schools of South Carolina than in any other.[12] There is no doubt that copious bleeding was primary

therapy in Florida for yellow fever, as well as everything else. Dr. Ayers P. Merrill was stationed in 1822 at Fort Barrancas near Pensacola. He reported to the Surgeon-General of his success several years earlier with yellow fever by bleeding thirty-six ounces at one time (followed by calomel, jalop, opium and mercury). As a prophylaxis, after the arrival of a detachment in a yellow fever area he bled each man of sixteen ounces.[13]

The reports of surgeons stationed at Fort Brooke (Tampa) before the Civil War show a similar reliance on bleeding and cupping for many ailments including the sudden transition of troops from "the cold climate of Maine to the almost tropical one of Tampa Bay."[5]

Elsewhere in the South before the War between the States, another strong advocate of bloodletting was Dr. Moritz Schuppert, a graduate of the University of Marburg, who came to New Orleans in the early 1850's. He described its use during his training:[14]

> "I occasionally attended in one or the other village a dozen of young, full-blooded country girls, who assembled at the house of one or another, and while the feet were immersed in a bucket of warm water, I opened the saphena veins, abstracting from twelve to sixteen ounces of blood from each one. This was done every year in girls from the time when sixteen years old, till they were married, and never did I hear of any bad consequences."

In 1861 in a pamphlet on gunshot wounds written for the surgeons of the Confederate States Army[15] Schuppert advised:

> "The best results follow venesection in the treatment of complicated gun-shot wounds. But, alas! the value of blood-letting, is like so many other valuable remedies, now discredited, and expectant homoeopathy seems to rule the day, so that young physicians are afraid to practice venesection."

Halstead in 1884 in his famous paper on exchange transfusion for illuminating gas poisoning, first bled the patient and then retransfused the defibrinated blood. (The term he used, "refusion", certainly is much more direct than today's, "autologuous transfusion.") But his report really is a description of the excellent effects of simple bloodletting on carbon monoxide poisoning.[16] He says: "Why then transfuse, if venesection accomplished so much? If for no other reason, to allow of repeated venesection."

However, by the end of the 19th century, there were few standard textbooks of medicine which advocated bloodletting.[17] It was well recognized that the bleeding and purging therapy had taken its toll, and in Florida as well. In an address on the medical history of Florida in 1877 Palmer decries the earlier use of the lancet "which exhausted the strength of the patient."[18]

Modern Usages

A bona fide case of wet cupping came to light in Tampa in 1979 when a patient with an unusual history was seen by one of us (J.C.):

> A Tampa welder-engineer, working for a maritime company in Nigeria, was wearing heavy boots and working on a piece of machinery in a room where the temperature was in excess of 120°F. Seeking relief from the heat, he went swimming and on emerging from the water developed swelling and pain in both legs. The German-speaking company doctor he went to see provided some treatment, but little rapport or relief. As a consequence he went to the local native doctor. That doctor sucked the air out of a hole in the small end of a hollow animal horn. He applied the horn to the skin and closed off the hole with a piece of rawhide he had been chewing. After the patient's skin had been raised by the vacuum thus produced, the doctor removed the horn and made multiple superficial cuts in the skin over that area. The animal horn was then reapplied in the same manner to the now lacerated area causing the extraction of blood and serous fluid. The treatment was applied to several areas.
>
> The patient reported relief from his pain and the swelling receded in his left leg. However, the swelling in his right leg persisted, and the company shipped him home for care. He was admitted to a Tampa hospital with a cellulitis, but also with nothing but praise for his native doctor. He was treated successfully with antibiotics and returned to Africa.

Photographs of the patient's skin, the lacerating implement which he brought with him, and a Nigerian animal horn used for such cupping are shown. The modern "lancet" appears to have been constructed from an automobile radio antenna and a piece of tin can.

In a less bizarre and very routine situation in modern medicine, massive venesection is performed for the sake of obtaining multiple samples for laboratory tests. In our need for blood with which to feed computer-operated, analytic assay machines, we have even recreated a special category of workers with the job title of "phlebotomist." Their National Phlebotomy Association was established in 1978. How many of these bleeders know that their lineage goes back to the barbers and the surgeons of the Middle Ages? And do the physicians who monitor their medications by blood sampling consider that, like Wafer in 1681, they are "administring both Physick and Phlebotomy to those that wanted"?

The need for repeated blood transfusions in the specialty of neonatology is a direct result of the anemia resulting from blood sampling. Even in the adult, the iatrogenic hospital anemia is well known. One elderly patient with postoperative complications had a documented 3,000 ml of blood drawn for laboratory assays during a 3½ month hospitalization.[19]

Therapeutic phlebotomy is still practiced in folk medicine and is also a mainstay in managing polycythemia. It has been revived recently in medical centers in a special form as exchange plasmapheresis where, like the old art of bloodletting it "eliminates rheumatic ailments, warms the marrow, clears the mind and makes the urine clean and clear."[20]

But do our modern reasons for bloodletting do ill or







Fig. 4 — Bloodletting in Nigeria 1979.

Fig. 4A — Animal horn used for cupping. (Smithsonian Institution Photo No. 73-5643).

Fig. 4B — Improvised lancet.

Fig. 4C — Cellulitis in a treated patient. (Photographs by Warren Chandler, St. Joseph's Hospital, Tampa)

good? Perhaps like our predecessors in the art of medicine, and their patients, we should respect the healing value of the loss of blood. An old English adage[17] may be true:

"A bleeding in the spring
Is Physic for a king."

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Florida Medicine and the War Between the States

William M. Straight, M.D.

In the drizzling rain of Monday, May 5th, 1862, the Second Florida Regiment, in their first general encounter, was thrown into battle at Williamsburg. With the steadiness of veterans they crossed an open field to drive the Union soldiers from a thickly wooded area beyond. They gained the edge of the woods, halted and opened fire but within moments their gallant commander, Colonel George T. Ward, lay dead of a bullet wound in the breast. Almost simultaneously the Union soldiers began to flank the Confederate right and it became imperative that they fall back. They repositioned behind an old fence line in the field they had just crossed and successfully resisted the attack. As soon as conditions stabilized the regimental adjutant, Lieutenant Charles Seton Fleming, and a party of volunteers set out to recover Ward's body which now lay between the lines. They reached the body safely but as they bore it toward the Confederate lines Fleming was, ". . . shot down; the ball entering just above and in front of the right hip, passing through the body and making its exit at the center of the back." His comrads attempted to carry him off the field but his pain being great and thinking himself mortally wounded, he begged them to let him die in peace. Acceding to his wishes they continued on with Ward's body. About sunset Fleming revived somewhat and dragged himself toward the Confederate line. By waving his sword he managed to attract the attention of the men of Starke's company who then brought him in.

Fleming was carried, first on a blanket and later on a litter, by soldiers of his company over a muddy, deeply rutted road to within half a mile of Williamsburg. He was left in the care of his brother, Francis P. Fleming, at an abandoned farmhouse while the soldiers went into Williamsburg in search of an ambulance. About midnight, when the soldiers had not returned, volunteers of a passing Virginia regiment hefted the litter and carried the wounded lieutenant on to Williamsburg. He was left, ". . . at the first large house which was lighted up," a house where a number of wounded were collected. There two surgeons, one from Georgia and one from Alabama, examined and dressed his wounds, gave his brother an order for brandy and advised him to get the lieutenant to a hospital as soon as possible.

With the dawn Francis Fleming set out to locate a hospital and obtain transportation for his brother. He quickly learned that the Confederate forces had passed beyond Williamsburg in their retreat toward Richmond and that Union forces were expected in the city at any moment. Unable to obtain assistance he was returning to the house of Mrs. Mary Claiborne, where his brother lay, when he was stopped by General J.E.B. Stuart commanding the Confederate rear guard. Stuart ordered him to join his regiment immediately and would not permit him to return to his brother. General Stuart assured Fleming that Confederate medical officers would be left in Williamsburg to care for the Confederate sick and wounded.

That afternoon the Union forces occupied Williamsburg without opposition. They allowed Seton Fleming to remain at Mrs. Claiborne's and she, ". . . took care of and nursed him with the devotion of a mother." Both Confederate and Union medical officers visited him from time to time and did what they could to ease his suffering. In a letter to his family he wrote, ". . . I suffered more from fever than the actual pain my wound occasioned." After seven weeks he was taken to a federal prison and when he was later exchanged he rejoined his regiment. He was killed at the battle of Gaines' Farm, June 3, 1864, in his twenty-fifth year.[1]

The Beginning

In the flush of excitement of Florida's Secession Convention, January 1861, as the delegates pinned on

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their palmetto cockades with blue ribbons, many were convinced Florida would be allowed to peacefully withdraw from the Union; the Constitution of the United States allowed this, so they understood. When they voted 62 to 7 for secession, they had no concept of the cost in men, money and human suffering that lay in the four years ahead. The firing on Fort Sumter, April 12, 1861, ended all hope of peaceful withdrawal and the War Between the States was on.

Suddenly it became necessary to mobilize, organize and train the Confederate States Army (C.S.A.) which at its peak strength (1864-1865) totalled about 484,800 men.[2] Hard statistics are not available but it is believed Florida supplied about 15,000 men.[3] There is no official and complete roster of the physicians from Florida who served in the C.S.A. but from many sources the author has accumulated the names of 118.

Physicians of Florida in the C.S.A.

A few of these 118 Florida physicians volunteered as privates in the line and remained in this capacity throughout the war. Most who entered as privates were later commissioned as medical officers. At least four physicians entered as line officers and remained in that capacity. One of these, Colonel George Troup Maxwell, a colorful physician who practiced before and after the war in several localities of our state, was colonel of the First Cavalry Regiment from its inception. He was captured at the battle of Missionary Ridge, Tennessee, and imprisoned for the remainder of the war by the Union.

A small number of these physicians served in Florida as contract physicians to army units or hospitals in their neighborhoods within the state. These men were given the title, Acting Assistant Surgeon, although they were usually merely addressed as "Doctor" and they were not entitled to wear the uniform of the C.S.A. Initially to serve as a contract physician the doctor must be fifty years of age or older but as the war drew on and civilian medical care was suffering from neglect, physicians were exempted from conscription if they were forty years of age or more and were needed in their neighborhood.

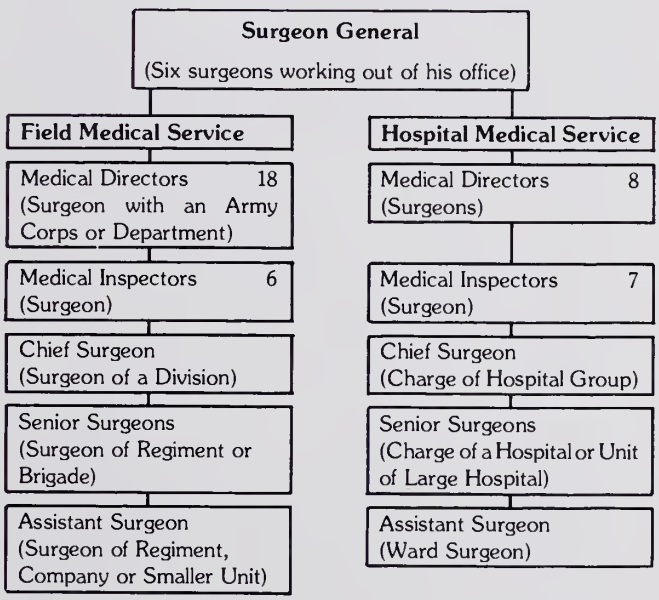
Contract surgeons received $6 per day to examine recruits, and $100 a month for the full-time supervision of a hospital (if the surgeon supplied the medicines he was allowed another $40 or $50 per month). If he accompanied troops in the field, he was paid $100 per month.

Most of the Florida physicians who served in the C.S.A. were commissioned as surgeons or assistant surgeons in the field or hospital medical services. The accompanying table gives an outline of the organization of the army medical department as it appeared on paper about 1864. Depending upon the demands of the moment and particularly as the war drew to a close, this was modified. The surgeon general had the rank of colonel and received $3,000 annually. Efforts were made to elevate his rank to brigadier general but these were unsuccessful. Surgeons had the rank of major and received $162 to $200 per month and assistant surgeons had the rank of captain with a salary of $110 to $150 per month. The exact salary varied with the length of service, and each rank carried certain allowances for fuel, quarters, etc.[4] It should also be noted that early in the war before the C.S.A. was completely organized some surgeons served for months without pay.

Within each state there were one or more medical directors whose duties included the general overseeing of the hospitals within the state, provision of medical officers for units operating in the state and the recruiting of medical officers. Surgeon Abel Seymour Baldwin, later the father of the Florida Medical Association, was the medical director of East Florida and Surgeon James Henry Randolf of North and West Florida. Later in the war Baldwin's authority extended to Quitman, Georgia, and still later over the whole of Florida.

Also, within each state were one or more medical purveyors whose duty it was to obtain and dispense medicines and hospital supplies to the hospitals and armed forces within the state. Surgeon John Edward A. Davidson of Quincy was the medical purveyor in Florida

Medical Department of the Confederate States Army*



*As it appeared on paper about 1864; modified from the Regulations of the Medical Department of the C.S.A. and Cunningham.[4]

The total number of medical officers that served the C.S.A. is thought to be 3,237: one Surgeon General, 1,242 Surgeons, and 1,994 Assistant Surgeons.[4]

throughout most of the war. In November 1864, a second purveyor, Assistant Surgeon Z. B. Herndon, was appointed and located at Lake City.

Confederate Hospital in Florida

The principal Confederate hospitals operating in Florida in 1864, are listed in the accompanying table. In addition to these there were hospitals established from time to time in connection with army units operating in Florida. Thus during the fighting at Pensacola in the fall of 1861, the Marine Hospital at Warrington served as a Confederate hospital. When General Braxton Bragg refused to move an artillery battery from in front of it, it was shelled from Fort Pickens despite its yellow hospital flag. This hospital ceased to exist when the Confederate troops were withdrawn in May 1862.[5] Similarly a hospital was established at Monticello in February 1864, to care for the wounded from the battle of Olustee (Ocean Pond). There were hospitals at Camp Simkins near New Port, at Gainesville and at Alum Bluff according to various sources. Finally, there is a brief mention of a "Prisoners Hospital" at Tallahassee.[6]

In addition to these officially constituted hospitals there were patriotic citizens who cared for the sick and wounded soldiers in their homes. One such was Dr. Edward Bradford who set up a small convalescent hospital on his plantation, Pine Hill, ten miles north of Tallahassee. Dr. Bradford had volunteered as a surgeon in the C.S.A. but the Secretary of War asked him to remain on his extensive plantation and supply food for the army. He fitted out three rooms in his large manor house and throughout the war received patients who walked in or were brought for convalescence from the Confederate hospital in Tallahassee.[7] The seventy-five bed hospital at Madison was a "Wayside Hospital" and designed to receive sick and wounded soldiers in transit to or from their homes on authorized furloughs.

Most of the Confederate hospitals in Florida were set up in buildings which had been constructed for other purposes. Thus in Marianna the old school house served as a hospital,[8] at Lake City a part of the hospital was in the Methodist Church[9] and in Tallahassee the City Hotel on South Adams Street, across from the west entrance to the Capitol served as a hospital.

Confederate General Hospitals in Florida — 1864*

Lake City	150 beds
Quincy	126
Tallahassee	100
Madison	75
Marianna	50
Camp Lay (Madison)	14

*Letter: J.E.A. Davidson to S.P. Moore, February 21, 1864, Davidson Papers.[17]

Life in these hospitals was somewhat different from that in today's hospitals. The nun of the Sisters of Charity who left a description of the hospital at Warrington was appalled at what met her eyes there:

> "The scene which met our view was heart rending in the extreme typhoid fever being the prevailing epidemic among its inmates and sad was the havoc it made among them . . . They had such a horror of the hospital they thought death was inevitable when once within its walls and would remain in their camps until it was too late (to) assist soul or body but the idea soon vanished when our presence was announced in camps they came in droves and on one occasion over 8 hundred came in with measles and not a vacant bed in the house they were satisfied to lie on the floor with their knapsack under their poor heads and one blanket for covering, and it fairly alive with vermin and fleas but not a complaint escaped from them. A number of them took other diseases in the hospital and died as they had lived . . .
>
> "It was heart rending to see them more like skeletons than human beings. The physicians treated them with the greatest indifference they prescribed without inquiring if their orders were executed or not. A few days after our arrival, I asked the daily physician if he knew that nearly all the fever cases had very serious bed sores and some were fetid and gangrene and two (sic) their clothing had stuck to their backs he seemed to be a little astonished, but it ended their with him. On investigation I found for seven weeks they had been lying in (the) same position and without a change of clothing and owing to the fetid smell when removed, we could not induce one of the men to assist in cleaning or purifying their sores."[5]

James Howard DeVotie, an apparently well educated and compassionate man who served as hospital steward at the Lake City hospital made similar comments about his facility:

> "The way the hospitals are managed is awful to see much filth, short rations and every lack of comfort or convenience you ever saw in you life . . . The surgeon Dr. Morall (J. S. Morel) seems to be perfectly unconcerned makes no effort to get anything the bedding is scarce changed filth reigns supreme."[10]

Later DeVotie has at it again:

> "The hospitals here are in a dreadful condition no physic hardly not a drop of liquor and twenty five or thirty cases of Typhoid Pneumonia. I leave you to imagine how great the mortality is among the poor soldiers . . . The men have been shamefully neglected both by the medical officers and the miserable nurses. Both seem to me either utterly indifferent or totally incompetent for the proper performance of their duties."[9]

The Lake City Confederate Hospital

An insight into the illnesses and treatment at the

Lake City Confederate hospital can be gleaned from two letterbooks, an account book, a furlough book and a casebook of this hospital which are at The Museum of the Confederacy in Richmond, Virginia.[11] This hospital received patients from many sources including the Howard's Grove Hospital and the Stewart Hospital in Richmond, several hospitals in Georgia and several army units on duty in Florida. While there were many cases convalescing from gunshot wounds, medical diseases accounted for most of the admission. The most frequent medical diagnoses are: chronic diarrhea (dysentery), remittent fever and intermittent fever. From the casebook in which each patient's name, army unit, diagnosis and treatment day by day is listed we will look at therapies for these three.

In those days diarrhea was merely diarrhea; salmonella, shigella, giardia, amoeba and the like were undiscovered and entities such as regional enteritis and ulcerative colitis had not been recognized. A typical therapy for diarrhea recorded in the casebook is that given Private Johnson, Co. "A", 1st Battalion, in May 1864:

Rx Tannin	m xxiv
Opium	m vi
Calomel	m xii

Mix and make six pills; give one every two hours.

At times ipecac was added to this formula and at times opium was used without the tannin or calomel.

The remittent fevers were those characterized by febrile spikes separated by intervals of lower but not normal temperatures. The temperature was likely gauged by the feel of the skin. Although the clinical thermometer appears as an item on the supply table, one for each 100 to 1,000 men, it is not likely there was a clinical thermometer at the Lake City Hospital. In those days it was a slightly bent glass tube designed for use in the axilla and with a scale that ranged from 75 to 115 degrees Fahrenheit.[12] One writer has said that there were not more than ten clinical thermometers in the entire C.S.A. and that the only surgeon to use the thermometer with any regularity was Joseph Jones, the roving inspector and investigator of the C.S.A.

The remittent fevers were what we call today yellow fever, typhoid fever and many other febrile entities. A typical therapy was that given Private Paul Colson, 5th Florida Battalion of Cavalry, in June 1864:

Rx Syrupus pruni virginianae	oz. iv
Spts. turpentin	drams i
Tinct. opium	drams i

Mix and give a tablespoon every two hours.



City Hotel — Confederate Hospital at Tallahassee — (Courtesy: Florida Photographic Archives)

The first ingredient in this prescription is syrup of wild cherry bark, an indigenous remedy thought valuable as a febrifuge. Other remedies recorded in the casebook for remittent fever are blisters over the stomach, emulsion of spirits of turpentine and "an injection" (enema) of starch every hour.

The intermittent fevers were characterized by fever spikes separated at fixed intervals by normal temperatures. These were divided according to the fever-free intervals into: quotidian (a daily fever spike but much of the 24 hours afebrile), tertian (two fever spikes in three days with one full afebrile day between) and quartan (two fever spikes in four days with two afebrile days between). These we recognize today as malaria but the malaria organism was yet to be discovered. In May 1864, Private James M. Bush of Co. "C" BB was treated for tertian intermittent fever with:

Rx Sulph. Quinine	m x
Pulv. capsicum	m xii
Carb. iron	drams i

Mix and make six powders; give one every two hours in a little syrup.

Other diseases seen in lesser numbers were: hepatitis, rubeola, scabies (treated with potassium iodide and sulphur), neuralgia (treated with the "galvanic battery"), syphilis and gonorrhea (treated with spirits of nitre and injections of silver nitrate up the penis). Although there are mentions of using the blister there are no mentions of bloodletting in this casebook. In the six volume *Medical and Surgical History of the War of the Rebellion*,[13] which records principally the Union experience, mention is made of a few trials of bloodletting in several diseases but it is evident that this had become a scarcely used therapy by the time of the War Between the States.

In the furlough book which contains 195 certificates of furlough, Surgeon Baldwin has recorded the diagnosis and the duration of the illness of each soldier he certifies for furlough. From this we learn that the average length of illness was six months. The most frequent diagnosis is gunshot wound, but there are others, some quite colorful. One certificate carries the diagnosis: "Pneumonia with hepatization of the lower lobe of the right lung." This suggests the use of the stethoscope and, indeed, the stethoscope appears on the supply table, one for each 100 to 1,000 men. How often and with what skill the stethoscope was used we have no way of knowing. Perhaps Baldwin used one for he was a superior physician for his day.

The medical staff of the one hundred and fifty bed Lake City hospital seems to have been one surgeon and one or possibly two assistant surgeons. Able Seymour Baldwin was the surgeon-in-charge during most of the war, in addition to his duties as medical director of East Florida. For short periods Surgeons J. S. Morel and Robert E. Moore served as surgeon-in-charge. Other physicians who served at the hospital from time to time were: Assistant Surgeons John C. L'Engle, Walter D. Colmar, P. Hutchinson and M. I. Nicholsen. DeVotie mentions the help of a Dr. Workman who may have been a contract physician to the hospital.

Food and Medicine Were Scarce and Costly

In a newspaper of the day[8] is recorded the cost of certain items purchased for the Lake City hospital in March 1865. Eggs were $2.50 a dozen, chickens $3 each, potatoes $5 per bushel, lard $2 per pound, whiskey $125 a gallon, soap $1 a pound, matches 50¢ a package and ink $6 a bottle.

Not only were foodstuffs expensive but medicines were equally costly if obtainable. So difficult was it to obtain medicines through the Union blockade that the Surgeon General ordered Surgeon Francis Peyre Porcher, lecturer on materia medica at the University of South Carolina to write a book on the indigenous medicinal plants of the South.[14] It was a popular idea of that time that in the fields and forests of each locale were to be found herbs that would cure the diseases of that area. Therefore the surgeon general's office sent circulars to the medical purveyors asking them to publish in local newspapers an appeal to the people of the South to collect and sell to the Confederacy many different roots, seeds and barks that might be used medicinally. Surgeon J. E. A. Davidson published in several local newspapers an appeal for: wild senna, wild cherry bark, Indian turnip, blackberry root, Virginia snakeroot, sassafrass and others on September 1, 1862.

One of the drugs in greatest demand was quinine for it was thought a specific for fevers of any kind. At the beginning of the war there were only two manufacturers of quinine, both in Philadelphia.[15] Despite elaborate attempts to smuggle quinine into the Confederacy, such as hiding it in mattresses, dolls and even in the carcass of a dead mule, it was always in short supply. At the beginning of the war it sold for $2.10 an ounce and by November 1863, it was bringing $75 an ounce at Lake City.[16] Various indigenous remedies were tried as substitutes and the surgeon general finally settled upon a compound tincture of dogwood, poplar and willow barks in whiskey. However, Surgeon E. D. Cherry of the 1st Georgia Regiment stationed at the Apalachicola Arsenal found ". . . the fevers here are so malignant in their character that they (the indigenous remedies) proved to be of no service . . ."[17] Medicinals became so valuable that armed couriers were hired to accompany the supply trains to and from the medical purveyors for these trains became prime targets for bandits.[18]

The prophylactic use of quinine against intermittents had been known for some years but quinine being in such short supply it was seldom available for this purpose.

Medical Care for the Home Folk

If medicinals were difficult for the army to obtain, they were more so for the civilians. Occasionally a supply of English or French drugs would slip through the blockade to be sold at prohibitive prices in the local "chemical store."[8] Rarely there seems to have been a patriotic chemist who sold at "the old prices."[19]

With most of the physicians off to war it was difficult for the home folks to find a doctor. At times physicians were implored to remain behind to care for the families of a group of departing soldiers,[7] but more frequently those who remained civilians were those whose age, infirmities or incompetence made them unsuitable for military service. When in late 1862, Surgeon Palmer requested leave of his post in Richmond to journey to Monticello for a month, he gave as one of his reasons: "I have also been invited to perform two very important Surgical Operations during the next month, on persons who cannot leave home to seek surgical aid, and there are now no surgeons in that part of the country who perform important operations."[20]

Surgeons with the Troops

Most of the Florida physicians who served the C.S.A. were with the troops in the camps, on the march and on the field of battle. None have left accounts of their experiences so we must draw on accounts left by Confederate surgeons from other states.

In camp the medical officer was responsible for locating the hospital tent and medical wagon, holding daily sick call, treating the sick and injured and super-

vising camp sanitation. Usually the medical officer tried to care for his men in camp rather than send them off to a stationary hospital. This not only pleased the commanding officer of the unit but was also the preference of the men. However, at times fierce outbreaks of disease dictated otherwise. As the articulate South Carolina surgeon and author of the *Manual of Military Surgery* commissioned by the Confederacy, J. Julian Chisolm, observed: ". . . the fire of the enemy never decimates the opposing army. Disease is the fell destroyer of armies and stalks at all times through the encampments."[21]

Diarrheas, dysenteries, fevers, pneumonia, measles, smallpox, scurvy and a host of other diseases attacked the troops. Since many of the soldiers in the C.S.A. had come from isolated rural communities where they had not been exposed to the infectious diseases, large numbers came down with the childhood diseases, smallpox and the like. Inadequate camp sanitation was another obvious reason for the prevalence of disease. The rural soldiers were reluctant to construct and utilize latrines and garbage pits. At times armed guards were stationed at the doors of hospital wards in Richmond to force the soldiers to walk the short distance to the nearest latrine.

On the march the medical officer had the least opportunity to demonstrate his diagnostic and therapeutic skills. A Tennessee medical officer, William H. Taylor, commented that on the march his practice of medicine was reduced to the lowest terms: "In one pocket of my trousers I had a ball of blue mass, in another a ball of opium. All complainants were asked the same question, 'How are your bowels?' If they were open I administered a plug of opium, if they were shut I gave a plug of blue mass."[4]*

Surgeons on the Battlefield

As illustrated in the account of the wounding of Lieutenant Seton Fleming in the opening paragraphs of this paper, early in the war there was no organized care for the wounded on the battlefield. In the spring of 1862, at the instigation of a Virginia surgeon, Hunter Holmes McGuire, the infirmary corps was organized.[4] This was a group of men "least effective under arms" who were under the command of an assistant surgeon and equipped with water, whiskey, splints, bandages and litters. With their assistant surgeon they advanced with the troops in battle to render first aid to those who fell wounded and then carry them to the field hospital a few hundred yards in the rear of the battle. The battlefield surgeon was expected to quickly examine the wounds on the spot were the soldier fell, stanch the flow of blood and splint broken limbs. He was not to bandage wounds in most instances for the bandage would just be wasted when it was removed a short while later at the field hospital. He must be cautious about applying tourniquets on the field for they might not be noticed at the field hospital until after the limb had become irredeemably ischemic.[21] With the establishment of the infirmary corps, troops who broke rank to care for the wounded were subjected to harsh punishment.

Despite the apparent exposure of assistant surgeons on the field of battle only one Florida medical officer was killed in combat. Assistant Surgeon du P. Hoover of the Eighth Florida Infantry was killed at Fredericksburg, Virginia, on December 12, 1862. The rarity of a surgeon being killed in battle may have been in part due to a certain courtesy extended to medical officers by both enlisted men and line officers. They were considered non-combatants by both armies. A green net sash identified the surgeon of either army. Often but not always surgeons left behind by retreating troops to care for their wounded were treated courteously and parolled to return to their units under a flag of truce when their services were no longer needed by the victorious army.

Surgery at the Field Hospital

Most of the surgery was done at the field hospital by the brigade or regimental surgeons assisted by one or more assistant surgeons. In extremity wounds where large vessels or nerves had been destroyed or joints had been penetrated, immediate (within twenty-four hours) amputation was advised. Amputation should be done as far from the trunk as possible except that a leg wound above the ankle dictated an above-knee amputation.

Missles and other foreign bodies should be probed for and "the finger is the proper probe."[21] Of course the finger was not gloved and often not washed. The finger



Field Hospital Union — (Harper's Weekly 6:824-825, Dec. 27, 1862)

*Blue mass was composed of elemental mercury, glycyrrhiza, althaea and honey of rose. It was a sialagogue and mild laxative.

had another use in probing the wound, to find if a cavity had been penetrated.

In abdominal wounds with unperforated bowel protruding the surgeon replaced the bowel and closed the wound. If the bowel was perforated he was to close the perforation with a stitch every one-sixth of an inch, replace the bowel and close the abdominal wall. If an extensive length of bowel had been injured or if the protruding bowel was gangrenous, the surgeon was to leave the injured bowel outside the abdominal wall and cover it with a wet dressing expecting it to eventually slough and leave a fistula which would ultimately close spontaneously. How skillfully these instructions of Surgeon Chisolm were carried out depended upon the courage, aptitude and training of the operating surgeon and the general condition of the patient. Chisolm records the overall mortality of abdominal wounds in which there was intestinal injury as 75%.

Transporting the Wounded

After the surgeons at the field hospital had completed their work the next step was transportation to a stationary hospital for convalescence and any secondary surgery. This required ambulances and often rail or water transportation. In the Confederacy from the beginning and throughout the war ambulances were in short supply. Often unspringed farm wagons were utilized to carry the wounded and frequently without the comfort of a canopy overhead or a bed of straw beneath the wounded soldier. The roads these wagons had to travel were usually deeply rutted by the artillery and frequently a quagmire of mud from the rains. Many a strong man is thought to have survived the field surgery only to succumb to the rough jolting of days in these wagons.

The Florida Hospital at Richmond

The establishment of a hospital system rated a low-priority in the confusion of the organization of the Provisional Government of the Confederate States and the mobilizing of the C.S.A. Thus the sick and wounded of the early engagements were usually cared for in makeshift hospitals set up in private homes, churches, store buildings, warehouses and hotels. With the mounting offensives around Richmond this chaotic state was forcefully brought to the attention of the Confederate Congress. In the spring of 1862 a start was made toward better organization of the hospital department. In September 1862, an act was passed decreeing that in so far as possible the sick and wounded should be segregated in hospitals according to their native states. Thus was born the Florida Hospital at Richmond which was also known as General Hospital No. 11 and as the Globe Hospital.[22]

Financing the Florida Hospital

The state legislature appropriated monies which were used to rent an unoccupied tobacco factory in Richmond. A part of this building still stands and is in use today at number 8-10-12 North 19th street. The building was completed in 1853 and despite ten fires over the 127 years the north wall and half of the east and west walls remain intact and in use. The top floor has been removed and the building shortened as is evident from the accompanying photographs. State funds furnished the hospital with 150 beds and bedding and with other needed furniture and equipment.[8] The Confederate government was responsible for the salaries of the surgeons and other attendants and for supplying medicines and food. In August 1863, it was estimated that the Florida Hospital



Florida Hospital, Richmond, 1865 — (Courtesy: Virginia State Library)



Florida Hospital Building, 1978

was costing the Confederate government between $5,000 and $7,000 per month.[8] In addition to the funds appropriated by the state legislature and supplied by the Confederate government the hospital received sums of money raised from private donors and from social events such as concerts put on by the ladies societies in cities throughout the state.

As not all of the Florida units were fighting with the army in the East, the state legislature appropriated $10,000 in late 1862 for the establishment of a Florida Hospital in the West. This hospital was never established despite repeated calls for it from high ranking Florida officers.

The Opening of the Hospital

The precise date upon which the Florida Hospital in Richmond received its first patient remains uncertain. On September 26, 1862, a Florida newspaper noted the formal opening of the hospital but added, "... it has been receiving and treating patients for several weeks."[8] In 1891 David Lang, Adjutant General for the United Confederate Veterans, stated the hospital was organized in August 1862.[3] Surgeon Palmer, surgeon-in-charge of the hospital from its inception and Mary Martha Reid, chief matron of the hospital, apparently arrived in Richmond in July 1862, for the purpose of setting up the hospital. Thus it seems likely the hospital first admitted patients in August 1862.

Some time in the winter of 1864 the Florida Hospital ceased to exist at the North 19th Street site and became a portion of the Howard's Grove Hospital on the Mechanicsville Turnpike. At this time Surgeon Palmer was assigned as surgeon-in-charge of the Third Division of that hospital and Mary Martha Reid as chief matron of that portion which now received the Florida boys. Surgeon Palmer reported for his new duty on February 6, 1864, suggesting this as the date the transfer was completed. Other surgeons who served at the Florida Hospital from time to time were: Surgeon Emil T. Sabal and Assistant Surgeons John P. Wall, John C. L'Engle and C. S. Garnett. A Dr. Green H. Hunter played a role in the establishment of the hospital but doesn't seem to have been a part of the medical staff.

The Surgeon-in-Charge

Thomas Martin Palmer, the surgeon-in-charge of the Florida Hospital throughout most of its existence, came to Monticello, from South Carolina in 1829, as a child of eight years. He acquired his elementary education at Monticello then attended the University of Maryland obtaining his doctor's degree in 1844. He returned to Monticello where he lived and practiced



Thomas Martin Palmer (1821-1895) — (Courtesy: Mrs. Tom Palmer)

medicine and surgery until his death in 1895 except for the war years. As an ardent southerner he was a delegate to Florida's secession convention. A robust, six foot four man of forty years he mustered in as Surgeon of the Second Florida Infantry Volunteers on July 13, 1861. Apparently he served without pay until January 1, 1862. A story is told that one day as the Second Florida was about to go into battle he noted a clump of trees that would make an excellent site for his field hospital. As he rode toward it he saw a group of Confederate officers ride up and occupy the site scanning the terrain with field glasses. Undaunted he rode up to the man he judged the senior officer, saluted and requested that they move on as he had selected the spot for his field hospital. The officer returned the salute, motioned to the others and they rode away. Sometime later he met that officer, General Robert E. Lee.

Palmer is described as a man of forceful yet kindly personality whose opinions were sought after and respected by people in all walks of life. Along with Dr. Abel S. Baldwin he was active in the founding of the Florida Medical Association in 1874 and he became the second man to serve as president of the FMA. When the infirmities of age and illness compounded by the deaths of his wife and only daughter weighed down upon him,

once again he showed his decisiveness. While the family were downstairs he took from the mantel in his bedroom the revolver he had carried in battle and shot himself. Still alive as the family rushed to the room he answered their query, "Why?" by saying that he was shooting at the pain in his side.[23]

The Chief Matron

The lady chosen to serve as chief matron of the Florida Hospital, Mary Martha Reid, was raised in a family of wealth and refinement. She became the third wife of the United States Judge at St. Augustine, Robert Raymond Reid, in November 1836 and bore him two sons one of which died in infancy. When Judge Reid was appointed Territorial Governor of Florida (1839-1841) she presided over Tallahassee society as the First Lady of Florida. At the end of his term of office they moved back to St. Augustine and shortly thereafter Judge Reid died of yellow fever. With a young son to support and educate she apparently took in boarders. At least we have a record of Bishop Whipple boarding with, "... Mrs. Reid, widow of the late Governor Reid," about 1843. He describes her in his diary as a very pleasant and agreeable lady.

At the outbreak of the War Between the States her son, then nineteen years of age, enlisted in the Second Florida Infantry. Probably soon thereafter Mrs. Reid went to Lake City to work in the Confederate Hospital there.[24] When the Florida Hospital in Richmond was being organized she was chosen as the chief matron and entrained for Richmond in the afternoon of Monday, July 14, 1862. She was escorted by Dr. Green H. Hunter of the Soldiers Relief Committee.

According to the regulations[25] the Florida Hospital was entitled to have two chief matrons at $40 per month plus rations and lodging. If there was a second matron, her name has not come down to us. Mrs. Reid's assignment was to exercise "superintendence over the entire domestic economy of the hospital." This entailed supervising the two ward matrons, two ward masters and a variable number of nurses (usually assigned enlisted men). These people in turn were charged with getting, preparing and distributing the food, providing linens and seeing that they were laundered, keeping the wards clean, administering the medicines and seeing to it that the severely ill or wounded received special nursing care. The name of only one member of her staff has survived, Wardmaster Private William W. Hubbard. He was paid $25 per month to care for the needs of 100 patients. Unfortunately, Mrs. Reid did not leave a diary or memoir but the interested reader will get a vivid picture of the chief matron's life from: *A Southern Woman's Story, Life in Confederate Richmond.*[26] The author, Phoebe Yates Pember, was chief matron of a section of the huge Chimborazo Hospital and writes very entertainingly.

From the beginning of the war living conditions in Richmond were difficult because of the massive influx of people related to the government and the war effort. Housing was difficult to find and very costly. A Richmond lady writes: "Our style of living was quite as simple as our dress . . . a single room, which served at the same time the purposes of kitchen, dormitory, and parlor for the lucky family that could secure even such comfortable accomodations. The simple dinner was cooked in a sauce-pan on a grate and often consisted only of potatoes and a very small quantity of meat and bread, varied with occasionally a fowl and tea."[27]

The cost of food and clothing rose constantly. Thus in July 1862, coffee sold for 50¢ a pound but by September 1863, it cost $5 a pound. As early as 1862 eggs were selling for $1 a dozen and butter a dollar a pound. In September 1863, leather shoes for ladies cost $50 a pair. A single room on the third floor without gaslight, fuel or a carpet on the floor rented for $60 per month. The Richmond lady tells us that by the summer of 1864, "... we very gratefully partook of our salt meat and dried peas, varied sometimes with a dessert of sorghum sirup."[27] Chief matrons were usually provided quarters in the hospital but possibly Mrs. Reid, like Phoebe Pember, preferred to live in town. Mrs. Reid speaks of meeting President Jefferson Davis on a street corner as she was "on her way to the hospital" one morning soon after her arrival in Richmond.[28]

The privations of life in Richmond were not the greatest trials for this empathetic lady. More trying was the suffering of the soldiers in the hospital and the haunting concern for her only son, by then a Lieutenant with the Second Florida in the field. The dreaded moment came when she received word that he had fallen in the Battle of the Wilderness (May 1864). Overwhelmed with grief, she asked that his body be sent to Richmond and she buried him in the Hollywood Cemetery there. Then as a seasoned trooper she "closed ranks" and returned to the hospital to serve the living.

Mrs. Reid served as matron of the Florida Hospital throughout its existence. When the fall of Richmond was imminent she left on the same train that carried President Davis and his entourage on Sunday night, April 2, 1865. She was not a member of his party but was allowed to travel with them as far as Abbeville, S.C. From that point she travelled along with the retreating soldiers of the Transmississippi Army as far as Washington, Ga. From there bands of Confederate soldiers escorted her to Chattahoochee where friends arranged her transportation to Monticello. Here she remained as a guest of her chief, Dr. Thomas Martin Palmer, for a time. Later she operated schools for girls and young ladies at Palatka, Jacksonville and Fernandina. Her last years were spent at the home of her nephew, Samuel Swann, in Fernandina where she died on June 24, 1894, at the age of eight-two.

The Florida Hospital Statistics*

Gunshot Wounds	360
Typhoid Fever	111
Catarrhal Fever	103
Rheumatism	48
Pneumonia	86
Diarrhea	71
Erysiplas	30
Neuralgia	12
Brain Inflammation	13
Hernia	3
Hemorrhoids	3
Ulcers	3
Syphilis	2
Asthma	1

*Report of Surgeon T.M. Palmer, September 26, 1863, as published in Florida One Hundred Years Ago, September 1963.[8]

Medicine and Surgery at the Florida Hospital

Almost no information about the practice of medicine and surgery in the Florida Hospital has come down to us. We do have a brief report of Surgeon Palmer to Governor John Milton in January 1863, and a second report after the hospital had been in operation a year. In the first report[8] Palmer states that since the opening of the hospital there had been thirty-four deaths from wounds or disease giving a mortality rate of 9.68%. He reported the average number treated monthly as 171 and the number in the hospital at the time of the report as 106.

The second report, made in September 1863, lists the frequency of the diseases and injuries seen at the hospital. Palmer states that a total of 1,076 patients had been treated at the hospital since it opened and that fifty-three had died. This gives the overall mortality of 4.9%, almost half of the previous mortality rate. Palmer notes that most of the deaths occurred during the months of December, January and February when, "typhoid fever and pneumonia prevailed more than at any other season, and both of these diseases are very fatal to our men . . ."[8]

No list of surgical operations performed at the Florida Hospital has come down to us, but Palmer in the second report says: "Many important surgical operations have been performed in this hospital without a single fatal case. Since the introduction of chloroform into general use, the terrors of surgery have been very much mitigated, and it is no uncommon occurrence now for men to beg to have a limb amputated or a bone resected. Under the benign influence of this valuable anesthetic, the shock of an operation is very much lessened and the danger is consequently very much abated; nor is its administration attended with any serious danger. Since the commencement of this war, it has been used in many thousands of cases without a single accident, as far as I have been able to learn."[8]

Mary Martha Reid mentions a William Barkes who had been wounded in the Brintow Station fight, November 1863. She notes, ". . . his leg was amputated by Dr. Palmer a few days ago — after giving every chance of saving it if possible. It has been an almost hopeless case from the first but seemed better yesterday . . ."[29] This was a secondary amputation, an operation generally considered more doubtful of a successful outcome than a primary amputation — within the first twenty-four hours of injury. Phoebe Pember states that in her experience secondary amputations "almost invariably ended in death." She goes on to state that the only cases under her observation who survived secondary amputations, ". . . were two Irishmen, and it was really so difficult to kill an Irishman that there was little cause for boasting on the part of the officiating surgeons."[26]

In the *Medical and Surgical History of the War of the Rebellion* are four very brief case reports by Surgeon Palmer. One of these records an operation at the Howard's Grove Hospital in June 1864, in which the upper four inches and the head of the left humerus of a Private T. Varnador, age 36, was resected. Varnador survived his surgery and was furloughed on November 10, 1864.[13] This operation was the recommended procedure for injuries of the heads of the upper extremities at that time.

Anesthesia

Chloroform was almost the only anesthetic used in the Confederacy. Although by this time most surgeons enthusiastically used anesthetics, there were a few who still maintained that anesthetics were deleterious in the treatment of gunshot wounds for they, ". . . add to the depression caused by the shock and retard union by first intention and predispose to haemorrhages and pyemia."[13] Chisolm states that of the many thousands of instances of its administration he knew of only two deaths attributable to its use. Statistics gathered by the surgeon general support Chisolm's view: of 6,784 instances of chloroform administration there were 5.4 deaths per thousand; of 1,305 instances of ether administration there were 3 deaths per thousand.[13]

As the best method of administration Chisolm recommends a cloth folded into the shape of a cone or a

common funnel with a sponge placed at the apex. Chloroform was dripped onto the sponge and the cone lowered slowly over the nose and mouth. When noisy breathing appeared the patient was ready for surgery and the chloroform was withdrawn to be restarted only if the surgical procedure was unusually prolonged.

If chloroform was not available the patient might be given a stiff shot of brandy or possibly "endermic" morphine. The endermic or hypodermic use of morphine had been introduced in 1855 by Alexander Wood of Edinburgh and first used in this country by Fordyce Barker in New York City in 1856. Chisolm had apparently obtained a syringe and used this method in his private practice prior to the war. However, the hypodermic syringe doesn't appear on the C.S.A. supply table and it is doubtful if it was used by the medical officers of the C.S.A. Morphia was given by mouth and rectum and may have been dusted into the wound on occasion.

Antisepsis/Asepsis

While anesthesia had become generally accepted, antiseptic and aseptic techniques in surgery were still aborning. As early as 1847, Ignaz Semmelweis had suggested the likelihood that the obstetricians' hands carried childbed fever to their patients. He recommended hand washing with a solution of calcium chloride but his concept met with violent opposition and was only slowly disseminated. Lister, who was unaware of Semmelweis' observation and who was already practicing scrupulous cleanliness, careful wound drainage and frequent dressing changes, was never-the-less appalled at his own surgical mortality. Having read of Pasteur's heat sterilization and realizing it was not applicable to human tissues he began to search for a method of chemical sterilization. He happened upon carbolic acid and first spoke of his dramatic lowering of surgical mortality in 1865. His first paper on the subject was published in 1867; both were too late for the surgeons of this war.



Surgeon's Pocket Case — (Courtesy: Dr. J. Andrew Burnam)

The concept that "laudable pus" was necessary for wound healing had been largely abandoned by the time of the war and tents and other foreign bodies were no longer inserted into wounds to bring forth laudable pus. Cleanliness of the hands and surgical instruments in the social sense was approved but surgical hand scrubbing and instrument sterilization as we think of it today was still a long way off. Thus Chisolm in his *Manual of Military Surgery*, 1864, makes no mention of even washing the hands or instruments before surgery. Samuel David Gross in his *System of Surgery*, 1872, the authorative surgical text of the nineteenth century, mentions the germ theory only to express his disbelief in it. He mentions carbolic acid for use on infected wounds but not as an agent for sterilization of instruments or the wound before and during surgery. As for hand washing he states that the surgeon should wash his hands "... in order that no dirt or perspiration may be deposited upon the wound, and thus become a source of irritation, interfering with the reparative process."[12]

Wound Care

The recommended wound dressing to be applied at the field hospital was a wet cloth covered with a piece of oiled silk or waxed cloth and secured by a single turn of roller bandage. If this were not available a cloth well greased with olive oil was a suitable substitute. A similar dressing was to be kept on the wound in the stationary hospital and in addition it was recommended that cold water be constantly dripped onto the dressing from a bucket suspended above the wound. Ice bladders made from india rubber or gutta percha were often applied to the wound to reduce inflammation.[21]

Depleting measures such as emetics, diaphoretics, purges and general or local bloodletting were no longer in vogue. Hemostasis was no longer achieved with the hot iron but instead compresses soaked in perchloride or persulfate of iron were recommended. When brisk bleeding was present the surgeon was advised to explore the wound and ligate major vessels with strong cotton, flax or silk thread.

The initial therapy of shock was a dose of morphine in brandy and water; this was more efficacious if administered hot. In addition the body was warmed with blankets, hot water bottles and rubbing the skin with pulverized mustard or red pepper. Blood transfusion had been tried before this war in Charleston and New Orleans[30]

and two instances of its use are cited in the Union army[13] but the author has found no mention of its use in the C.S.A. The discovery of blood types and the need for cross matching to permit safe transfusions was still forty years in the future.

Surgical Diseases

The scourges of the hospital surgeon were erysiplas, hospital gangrene and pyemia. When cases of these diseases appeared in a hospital they must be immediately isolated from the other patients and if a number of cases developed the hospital must be closed for thorough cleansing and purification. Apparently one or more of these diseases forced the temporary closure of the Florida Hospital in the winter of 1863. Surgeon Palmer received an order from Chief Surgeon A.S. Mason on February 16, 1863, to transfer the badly wounded to General Hospital No. 21 and all others to the General Hospitals Camp Winder and Chimborazo, "Then proceed to cleanse and thoroughly purify your hospital."[31] After the hospital was cleansed it was reopened for the reception of the sick and wounded on May 6, 1863.

Erysiplas was thought due to overcrowding, bad ventilation and want of cleanliness. Patients with this disease were to be isolated in a large airy room, allowing 100 square feet per patient, or better in a tent pitched outside on the hospital grounds. The patient's sponges and bandages were not to be used on other cases. He was to receive alcohol as a stimulant and to be given a nourishing diet. The infected area was painted every three hours with tincture of muriate of iron, ten drops in a wine glass of water. Some surgeons preferred perchloride or persulfate of iron and still others tincture of iodine or silver nitrate.

Hospital gangrene was thought to be blood poisoning that resulted from, ". . . a foul and infected atmosphere operating upon a depraved and enfeebled constitution." It was recognized as both contagious and infectious and as transmitted by sponges or dressings. However, Chisolm states that this disease was particularly rampant in 1863 when there was no want of cleanliness and no overcrowding in Confederate hospitals. In that year, ". . . even the small prick in vaccination would, in some instances, become frightful ulcers, and even lead to the destruction of life."[21] As in erysiplas the patient was isolated and the greatest attention was paid to cleanliness. At times the actual cautery was applied to the wound area. Wounds were painted with iodine or strong nitric acid (morphia or chloroform were used to allay the extreme pain of this procedure) and poultices of charcoal, flaxseed or meal soaked in pyroligneous acid (acetic acid), turpentine or creasote were applied.

Pyemia (septicemia) while a rare disease in the Confederate army was usually fatal. Chisolm reports fifty-two cases in the course of 1,507 amputations of "large limbs" between October 1862, and October 1863. Of these only a single case survived. Pyemia was thought to be closely related to erysiplas and hospital gangrene and the therapy was essentially the same as used in those diseases.

Another infrequent disease, but one that carried a high mortality then as it does now, was tetanus. Although its association with wounds was acknowledged, at times it was thought to arise spontaneously because of "sudden atmospheric changes in connection with dampness." Therapy consisted of bland dressings on the wound, large doses of brandy and opium, inhalations of chloroform and nasogastric tube feeding.

Scurvy and Smallpox

Scurvy was a common disease and debilitated the soldiers to such an extent that it was thought responsible for many of the poor operative results. Within a few months of the beginning of the war fresh vegetables and fruits were in short supply and scurvy appeared. By 1863, Surgeon Lafayette Guild detected "a tendency to scorbutus throughout the whole army." All sorts of herbs such as: sassafras buds, wild onions, garlic, lambs quarter, poke sprouts, sauerkraut, molasses and sorghum were used to combat it. Perhaps the most effective were lime and orange juice which was sent to the hospitals at Richmond.

A disease that was distressingly common among the unseasoned troops and which carried a high mortality was smallpox. This was epidemic in the fall of 1862 and the winter of 1863-1864. Indeed, it was so prevalent that a separate smallpox hospital was established in Richmond. Of 2,513 cases in Virginia hospitals between October 1, 1862, and January 31, 1864, there were 1,020 deaths.

Although vaccination had been introduced more than sixty years prior to the outbreak of the war, most Confederate soldiers had neither been vaccinated nor experienced the disease. Calf lymph vaccine was developed in Italy in 1845 but it did not reach this country until 1870.[32] Vaccination of the Confederate soldiers was done using serum or crusts from other successful vaccinations. Physicians and lay people were urged to collect crusts and forward them to the nearest army purveyor. Assistant surgeons were assigned to vaccinate children in the large cities and to collect the crusts of all "takes." Whereas the surgeons used a needle or lancet, soldiers and civilians often vaccinated each other using common pocket knives. Whether done by surgeon, soldier or civilian the procedure was unsterile and at times led to loathsome ulcerations. In June 1863, Surgeon Palmer was notified of the existance of, ". . . a particularly annoying and disgusting skin disease accompanied with constitutional derrangement produced, it is supposed, by the use

of inferior or spurious vaccine virus."[33] This entity later dubbed "spurious vaccinia" was so great a problem that 5,000 men of Lee's army were unable to participate in the battle of Chancellorsville, May 1863, because of it.

On occasion syphilis was thought to have been transmitted by vaccination. Surgeon William Fuqua of the 7th Florida Regiment reported, ". . . offensive and freely discharging ulcerations with, in some instances, swelling and suppuration of the axillary glands," in fifty-two men who were vaccinated with vaccine matter obtained from a sailor with primary syphilis.[13] Of course it is more likely Surgeon Fuqua was observing lymphadenitis due to staphylococcus or streptococcus than syphilis.

The Summing Up

Florida physicians were among the most loyal supporters of the Confederate cause in our state, with the troops in the field and in the stationary hospitals of the Confederacy. Frequently overworked they none-the-less worked diligently and skillfully to alleviate the horrors of war despite severe shortages of medicines, supplies and even food. Judged in the light of the medical knowledge of their day they deserve our respect and admiration.

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Twenty-Five Years Ago

In *The Journal of the Florida Medical Association* for August 1955:

One hundred seven Florida physicians representing 30 communities attended the 1955 Annual Meeting of the American Medical Association in Atlantic City . . . FMA Medical District Meetings were announced for October 10 in Fort Lauderdale, October 11 in Lakeland, October 12 in Gainesville, and October 14 in Pensacola . . . **George S. Palmer, M.D.**, of Tallahassee, a future FMA President, was appointed to the Florida State Board of Medical Examiners . . . The University of Miami School of Medicine honored **John D. Milton, M.D.**, and **Franz H. Stewart, M.D.**, for "service rendered as pro-tem department heads for the school year 1954-55." . . . A major tabacco manufacturer sponsored an advertisement offering "a few facts for the busy doctor who wants the latest information about filter tip cigarettes" . . .

And so it was in Florida medicine 25 years ago this month. — E.D.H.

Professional Liability Legal Update

Informed Consent

The American legal system places great importance upon an individual's right of self-determination. This basic right has always been particularly applicable to decisions regarding one's own body. The doctrine, as applied to the field of medicine, was classically expressed by Justice Cordozo in 1914: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages."

The fact that an operation or medical procedure will be for the benefit of the patient will not justify a doctor in proceeding without proper consent. Thus, absent unanticipated conditions or an emergency, a physician must obtain the consent of the patient, or if an incompetent, consent of someone legally authorized to give it, before any treatment is commenced.

Under the Florida Medical Consent Law, no recovery is allowed against any physician in an action brought for treating, examining, or operating on a patient without his informed consent when (1) the action of the physician in obtaining the consent of the patient or another person authorized to give consent for the patient was in accordance with an accepted standard of medical practice among members of the medical profession and with similar training and experience in the same or similar medical community; and (2) a reasonable individual, from the information provided by the physician, under the circumstances, would have a general understanding of the procedure, the medically acceptable alternative procedures, or treatments, and the substantial risks and hazards inherent in the proposed treatment or procedures, which are recognized among physicians in the same or similar community who performs similar treatments or procedures. Likewise, failure to give the foregoing informed consent is excused if the patient would reasonably, under the circumstances, have undergone such treatment or procedure had he been advised by the physician in accordance with the foregoing. A written consent which is signed by the patient or another authorized person and meets the requirements of the Consent Law, is conclusively presumed to be valid.

The extent of the physician's duty to inform the patient was aptly described by a Florida Court which said that the duty of a medical doctor to inform his patient of the risks of harm reasonably to be expected from a proposed course of treatment does not place upon the physician a duty to elucidate upon all of the possible risks, but only those of a serious nature. Nor does it contemplate that the patient or those in whose charge he may be are completely ignorant of medical matters. A patient is obliged to exercise the intelligence and act on the knowledge which an ordinary person would bring to the doctors' office. The law does not contemplate that a doctor need conduct a short course in anatomy, medicine, surgery, and therapeutics, nor that he do anything which in reasonable standards for practice of medicine in the community might be inimical to the patient's best interests. The doctrine of informed consent does not require the doctor to risk frightening the patient out of a course of treatment which sound medical judgment dictates the patient would undertake. Nor does the rule assume that the patient possesses less knowledge of medical matters than a person of ordinary understanding could reasonable be expected to have or by law should be charged with having. Nor should the rule declaring a duty to inform be so stated or applied that a physician, in the interest of protecting himself from an overburden of lawsuits and the attendant costs upon his time and purse, will always follow the most conservative therapy — which, while of doubtful benefit to the patient, exposes the patient to no affirmative medical hazard, and the doctor to no risks of litigation. Thus, the information required of the doctor by the general rule is that information which a reasonably prudent physician or medical specialist of that medical community should or would know to be essential to enable a patient of ordinary understanding to intelligently decide whether to incur the risks by accepting the proposed treatment, or avoid that risk by foregoing it. A doctor or specialist who fails to discharge this duty to inform would thus be liable for negligence to the patient for the harm proximately

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Prepared and submitted by John E. Thrasher, J.D., Vice President and Legal Counsel, and Anthony J. McNicholas III, J.D., Associate Legal Counsel, Professional Insurance Management Co. (PIMCO), Jacksonville, Florida.

resulting from the treatment to which the patient submitted.

Although the legal principles pertaining to informed consent are fairly straightforward, application of these principles to individual patients is often very difficult. There are several basic guidelines, however, which, if followed, and if applied to each patient based upon his individual needs and circumstances, will assist you in providing the patient with the information required to make an intelligent, informed decision regarding his proposed treatment. The first and most important thing to keep in mind is that the ultimate decision concerning the proposed treatment belongs to the patient. Admittedly, it is often easy to lose sight of this in view of the fact that patients are constantly deferring to the physician's judgment regarding their treatment. However, if you can guard against, consciously or unconsciously, excluding the patient from this decision-making process, and make him feel that you are genuinely attempting to provide him with information that will allow him to make the final determination regarding his treatment, you will have taken the first step in fostering the physician/patient relationship that is crucial to informed consent.

When discussing treatment with the patient, it is advisable to have his spouse or other close relative present during the discussion, unless the patient prefers otherwise. The spouse's presence can help make the patient less apprehensive and give the patient someone to talk with about what you have said. This will improve the patient's recall of your discussion and increase the spouse's understanding of the course of treatment, hopefully eliminating a source of future confusion or dissatisfaction.

In your discussion with the patient, you should avoid misleading him or giving the suggestion that you are in any way guaranteeing the results of an operation or treatment. You should take care that kindly assurances of concern and hope are not construed as an opinion that there is "no risk" involved in the contemplated procedure. There is often a fine line between consoling and misleading, but you should always do your best to determine where that line lies.

After your discussion with the patient, you should encourage him to ask questions, which should be answered as completely as possible. The question and answer session should end with you asking the patient, "Now that I have explained to you the procedure, the alternatives to it, and the substantial risks and hazards involved, do you want to go ahead with the course of treatment that I have recommended?" At this point, you have fully discussed the proposed treatment, answered all questions, and left the final decision on whether to proceed with the patient.

Finally, the patient should execute a properly detailed written consent to the proposed treatment. Furthermore, immediately after a patient has left your office, it is strongly recommended that notes of your informed consent discussion be dictated for your records.

Campaign Spending

Americans spend more money on lipstick and garden hoses than they spend on federal elections, American Medical Political Action Committee (AMPAC) Chairman Michael Levis told conference delegates.

He rejected assertions that political action committees spend too much money to influence congressional elections.

In a speech on the health profession's role in political action, Dr. Levis, a physician, said Americans spent $192.2 million in 1978 on House and Senate races. Thirty-two million of that amount, or 16%, was spent by PACs.

While spending $192.2 million to elect their government representatives at the national level, Americans spend $220 million on garden hoses, $300 million on nail polish, $668 million on lipstick, $775 million on men's fragrances, and $4 billion on dog food, he said.

Speech before Onondaga County (NY) Medical Society (February 5, 1980)

SPECIAL ARTICLE

To Be A Doctor

Donald L. Custis, M.D.

Today, you are a doctor.

It is a privilege for me to join your faculty, families, and friends on this happy occasion. All of us share with you the pride and satisfaction you must feel for a difficult job well done.

An academic commencement for most graduates connotes an end and a beginning, but for you, this day is only a milestone in a continuum of effort since the time you first told yourself "I want to be a doctor." It was then your conditioning began with the earliest contemplation of this fascinating discipline. It will continue for decades as you acquire and keep pace with the ever evolving science of medicine. It is that dynamism, which makes your opportunities so challenging.

The vocabulary of medicine is replete with words that express the ideas from which they sprang. The original meanings of three words — physician, medic, doctor — are highly illuminating. The word "physician" derives from the Greek *physis* or nature, denoting that the physician has his roots in the understanding of the nature of things; the word "medic" comes from *mederi*, to heal, and the root *med* means to meditate or think, so that medic is equivalent to thinker and healer; the word "doctor" originally meant master or instructor. Thus, semantically, our profession involves learning, knowing, healing, and teaching. In modern parlance, we speak of research, education and patient care.

The stole you have earned today comes from the colorful fabric of a long history of medicine, a fabric woven from the ideals and achievements of colleagues through all periods from Hippocrates and Vesalius; to Osler and Fleming. It is a symbol of your eligibility for an awesome trust known through the ages as "medical authority." This particular credential is not conferred on any single ceremonious occasion, but acquired gradually as you demonstrate competence in patient care and professional credibility. It is a powerful authority not given in full measure to any other profession. it is as old as the Hippocratic Oath. From earliest recorded times, and in every culture of which we have knowledge, the shamans, healers, or, later, the physicians have been trusted to exert a massive influence on both their patients and society. Yet the ingredients of such authority remained ill defined until recent times.

Doctor Humphrey Osmond, on whose work I draw heavily in this address, has written a delightful article, appearing in *The New England Journal of Medicine* last March, analyzing in depth the nature and the implications of the physician's authority. He credits T. T. Paterson as having provided the title and definition of "Aesculapian authority" claiming for it three ingredients — sapiential, moral, and charismatic, all combined in a unique manner.

By sapiential authority, Paterson means the right to be heard that is derived from knowledge of medicine. Such authority resides in the person and not in any position he may occupy. With this authority he may advise, inform, instruct and direct, but not order. If the doctor's authority were only sapiential, then a well established physiologist would have much more authority than a newly qualified doctor. But in fact, when there is an illness, any doctor is preferable to any physiologist, which makes it clear that the doctor has been accorded something more than sapiential authority.

The second ingredient of Aesculapian authority is moral authority: the right to control and direct that is derived from rightness and goodness according to the ethos of the enterprise. This moral authority has expression in the Hippocratic Oath, a commitment to ethical behavior and concern with the good of the patient.

The third ingredient in Aesculapian authority is charismatic authority, the right to control and direct that is derived from God-given grace. This element, says Dr. Osmond, reflects the original unity of religion and medicine that still exists in many parts of the world. In western culture, the charismatic element in medicine has

The Author

DONALD L. CUSTIS, M.D.

Dr. Custis is Chief Medical Director for the Veterans Administration. This paper was originally presented at the University of Florida College of Medicine Commencement, May 31, 1980.

to do with the possibility of death, which accounts for the seriousness of the enterprise, and with the impossibility of fully assessing the doctor's knowledge. There are too many unknowns and, at present, unknowable factors in illness for medicine to rest entirely on sapiential authority. Hence, the doctor is still accorded some of his original priestly role. He is not always expected by his patient to be entirely rational, the latter also knowing that medicine deals with mysterious forces not completely amenable to reason.

My thesis has to do with the unusual difficulties you will encounter in the exercise of Aesculapian authority in the socio-economic and political milieu of modern medicine. Never has there been a time of such critical need to protect and hold sacrosanct the physician's heritage of trust.

The entire environment in which you will practice is undergoing tremendous change involving the science of medicine itself, the attitudes of patients, the credibility of physicians, and an intense involvement of society in the restructuring of modalities for medical care delivery. In the context of this turmoil, you will be key participants in a structural transition reflecting the attitudes, culture and customs of a restless society interacting with a prestigious and conservative profession. The continued productivity of medical research, quality of patient care, and the effectiveness of the provider will depend, in large part, upon how well you exert your influence, exercise the art and maintain the integrity of your profession.

Public dissatisfaction with its health care system is a favorite matter of conjecture in Congress and in the press. Their depreciations are a paradox, indeed at times schizophrenic when measured against the great success of recent decades of American medicine. One could rightly say that "never has anything sounded so bad which has actually been so good."

Any true perspective starts with retrospection. Author-physician Lewis Thomas describes it this way: Modern medicine is but a little over 100 years of age. The revolution in medical knowledge began with the destruction of dogma. Prior to that, and way into the millennia of its origin, medicine got along by the crudest sort of empiricism. It was, in retrospect, the most frivolous kind of human experimentation. Bleeding, purging, cupping and the infusion of every known plant and element, based on the weirdest imaginings about the cause of disease — this was the heritage of medicine prior to the application of modern science.

In the latter half of the last century, Doctor Oliver Wendell Holmes, then Professor of Anatomy at Harvard Medical School, said in a lecture to the Massachusetts Medical Society:

> "I firmly believe that if the whole *materia medica*, as now used, could be sunk to the bottom of the sea, it would be the better for mankind, and all the worse for fishes."

Then gradually over the succeeding decades old therapeutic rituals were abandoned and the natural history of disease was meticulously observed. Accurate diagnosis and so called "supportive treatment," with a measured degree of trust that nature would take its course, became the principle armamentarium of the doctor. Except for some preliminary discoveries in bacteriology, immunology, and endocrinology the physician's ability for curative effort began with my generation. The advent of sulfonamides and penicillin ushered in the age of curative medicine, with all of the subsequent triumphs in biomedical science and technology, with which you are familiar.

The acquisition of knowledge has always given us a greater insight into the depth of our ignorance and the compulsion to plumb deeper into the mysterious intricacies of nature. We are still confounded by heart disease, stroke, cancer, arthritis, cirrhosis, nephrosis, schizophrenia, and the degenerative, nutritional and viral diseases about which we know too little.

And yet, there has never been a period in medicine when the future looked so bright for the ultimate understanding of all human disease — and thanks to the cell biologist — perhaps the very nature of life itself. All of these were unthinkable a half-century ago.

Ironically, now that the physician can be of the greatest help to his patient, the latter has never been more critical of him. Well people have seldom revered their doctors for, at best, they can be awkward reminders of bad times. Individually, the Aesculapian authority is still recognized when most people fall ill, albeit qualified by the popularity of a "second medical opinion."

Collectively, today's society is more educated, more distrustful of any authority, more cynical of professed motivations and more demanding of personal attention. Thanks to medical advances, most people reach adulthood without having experienced a serious illness, and are ill prepared to handle the sick role. Many are conditioned to expect medical care as a right, cure a guarantee, and commonly have an impulse to sue should those expectations be denied. Even the satisfied patient now finds the expense of medicine too great when seen from the vantage point of health restored. Not unrelated, in these egalitarian times, is the prevalent perception that doctors are more interested in their income than in their patients.

There is abroad in society a very superficial simplistic understanding of the shocking escalation in health care cost, namely, that doctors and hospitals charge too much. Not appreciated by consumers and their political representatives are the high costs of medical technology, excessive patient demand, federal regulation, socio-

economic programs hung onto the medical model, inflation, and the expensive people intensity of the system.

That is where we have been, and from where we have come. Where will we go now?

Our society has prided itself on free enterprise, competitive institutions, and individual initiative. Any monolithic centralized national health care service is a concept out of context. Whatever choice the public ultimately makes in restructuring the system is not likely to violate those cultural values — and not likely to abandon the pluralism, voluntarism and competition featured in medical care delivery today.

You, in all of your many roles, will have the opportunity to participate in these options. I urge your to seize that opportunity. Your concern will be to protect quality, but you will have to be conscientious in your judgments of what quality is — and isn't.

Your future roles are also at stake for the competition for funding may yet bring a legislated arrangement for more and more public subsidy. Already over one-half of hospital and medical school dollar input is of federal, state and local tax origin.

It seems clear that, as more responsibility for medical financing is centralized in government, the work of physicians will be increasingly subject to public, or at least bureaucratic, scrutiny. Whether this works to public benefit is problematic. But what is certain is that like other public servants, physicians are finding it increasingly difficult to make professional judgments within the Aesculapian model I have discussed.

Some physicians suffer poorly societal oversight of their profession judgment and behavior. There is a temptation to take a defensive stand on the moral and charismatic elements of Aesculapian authority. Nothing can appear more arrogant than an overt display of moral superiority. Hence, the origin of such stories as that of a Pope, who dies and goes to heaven only to be kept waiting at the pearly gates by St. Peter. While so detained, he observes a new arrival, a little man wearing a white coat and a stethoscope, to whom Saint Peter shows great deference and ushers him into heaven. The Pope is incensed and demands to know why that "pill pusher" was admitted ahead of him. "Quiet," said Saint Peter, "that was God. Sometimes he thinks he's a doctor."

Yet, it does not become the physicians of today to exhort you, the physicians of tomorrow, to stand sentinel over yesterday's order of things. In a very real sense, the fluid status of the medical model can be your best opportunity. The restructuring of the mores and modalities of medical practice is a task worthy of your restless minds and willing hearts. The moral order of medicine and indeed of society itself is never static. It is not something enshrined in historic documents and stowed away like the family silver. You will recreate it in accordance with **your** values and **your** convictions as you experience the dilemmas, the success and the failures of **your** time. And you will likely do so in consultation with lawyers, theologians, and social scientists for critical new treatment technologies are raising questions concerning ethical and humanitarian imperatives never previously faced.

The words of Polonius — "To thy own self be true" — need not be so much an admonition as a prediction; for you, through your own experience, will learn anew that all that is creative is ultimately a moral affirmation — bring with it the faith that dares in the absence of certainty and the courage to go forward in the face of adversity.

Because you are students of human nature, it will be given to you more than most to understand the lack of moral economy in this universe. Many people have a great deal of difficulty with the fact that virtue is not always rewarded nor is evil always punished. To handle tragedy may indeed be the mark of the truly educated man. To say that is not to encourage resignation to the whims of fate, but to acknowledge the need for forethought about how to cope with undeserved reverses.

Ask any successful adventurer for the secret of his achievement and preparation gets much of the credit — preparation for success and failure. In your career of human service, there is no room for amateurs or dilettantes. Demanding, rewarding, exhilerating — you have a tremendous role. Play it well and you alone can make a difference.

You knew in your mind and heart that you answered a call to such adventure the day you decided "to be a doctor."

Good luck — and God go with you.





Dr. Smith

A $1 million endowed professorship . . . has been established at the University of Florida College of Medicine, and **Richard T. Smith, M.D.**, Professor and Chairman of the Department of Pathology has been appointed to fill it.

The position will be called the Chandler A. Stetson Chair of Experimental Medicin in honor of Dr. Stetson, who served as Vice President of the University for Health Affairs and Dean of the College of Medicine until his death in 1977.

Funds for the research chair were received from anonymous private donors through a development program that was initiated three years ago, according to departing **Dean William B. Deal, M.D.**

In announcing Dr. Smith's appointment, Dr. Deal said the chair was designated for a nationally recognized researcher in the field of pathology. Dr. Smith is an internationally known immunologist and pediatrician. He was first Chairman of the University of Florida Department of Pediatrics before assuming the pathology chair in 1967.

Twelve Florida physicians . . . were elected to Fellowship in the American College of Physicians at its 61st Annual Session in New Orleans. The Floridians are:

Brian G. Salisbury, M.D., Clearwater; **Raymond L. Parker Jr., M.D.**, Coral Gables; **William B. Deal, M.D.**, Gainesville, who has since assumed a position with the AMA in Chicago; **Philip G. Boysen, M.D.**, Gainesville; **Gary H. Lyman, M.D.**, Lutz; **Richard N. Baney, M.D.**, Melbourne; **Martin Arostegui, M.D.**, and **Jose S. Bocles, M.D.**, both of Miami; **Seymour S. Feld, M.D.**, Miami Beach; **Lewis H. Kaminester, M.D.**, North Palm Beach; **Joseph W. Warren, M.D.**, Orlando; and **Alan T. Leibowitz, M.D.**, Tampa.



Dr. Patterson

James N. Patterson, M.D., of Tampa . . . has been honored for distinguished service by his alma mater, Bucknell University in Lewisburg, Pa. Dr. Patterson, a member of the Class of 1924, was cited for service to his fellow man.

The citation, presented at Bucknell's annual Alumni Reunion Weekend on June 6-8, stated:

"His distinguished career in medicine spans 50 years and he is renowned for his work with blood. His writing in conjunction with an associate, **Dr. Frank C. Coleman**, on Rh (D) Immune Globulin Therapy, has been distributed world wide, and as a result of this technique, hemolytic disease of the newborn was given the status of preventable disease, saving some 5,000 lives each year."

Dr. Patterson, is a former President of the American Board of Pathology.

Alvin Taylor . . . has been appointed by Gov. Bob Graham to be Secretary of the Florida Department of Health and Rehabilitative Services. He succeeds David Pingree, who was moved to the Governor's Office as Deputy Chief of Staff.

Taylor, 38, has been Deputy Secretary of HRS since 1979. He becomes one of the Administration's highest ranking black officials. As Secretary, he will oversee Florida's Medicaid and other state health programs.



Dr. Green

Jacob Green, M.D., of Jacksonville . . . has been elected President-Elect of the American Medical Electroencephalography Association. The 650-member group met recently in Nashville, Tenn.

A graduate of the University of Alabama School of Medicine, Dr. Green is a Past President of the Florida Society of Neurology and currently heads the Jacksonville Society of Neurology.

Three Florida physicians . . . have recently been certified as fellows of the American College of Anesthesiologists. The new fellows are **Terence J. Gilbert, M.D.**, Ft. Myers; **Philip R. Hanlon, M.D.**, Panama City; and **Dennis P. Molinari, M.D.**, Sarasota.

The Joint Commission . . . on Accreditation of Hospitals scheduled surveys of six Florida hospitals during July, August and September. They are: North Ridge General Hospital, Fort Lauderdale; Naples Community Hospital, Naples; St. Petersburg General Hospital and St. Petersburg Osteopathic Hospital, both of St. Petersburg; Doctors Hospital of Sarasota; and Community Hospital of the Palm Beaches, West Palm Beach.

The American College of Radiology . . . has accepted as new members six Florida physicians. The newest ACR members are **John Jacob Baehr III, M.D.**, Pensacola; **Jack Kaplan, M.D.**, and **Howard Rubinson, M.D.**, both of Miami; **Pedro Soler, M.D.**, Marianna; **Neil Steinmetz, M.D.**, Lake Worth; and **Leonard Toonkel, M.D.**, Miami Beach.



Dr. Rhoton

The Division of Neurosurgery . . . at the University of Florida College of Medicine has been elevated to departmental status, according to **Acting Dean J. Lee Dockery, M.D.** Appointed Professor and Chairman of the new department was **Albert L. Rhoton, M.D.**, Chief of the neurosurgery service since 1972.

The upgrading in status will allow the Department to function on its own regarding budget, research, house staff and grant distribution. Previously, it was a branch of the Department of Surgery.

Dr. Rhoton, an internationally renowned expert on microneurosurgery and a pioneer in that field, for the past two years has occupied the endowed "R. D. Keene Family Professorship of Neurosurgery."

Dr. Dockery praised Dr. Rhoton and the other members of the neurosurgery faculty for the international scientific recognition they have earned.

"The achievements in patient care and training have made the department outstanding and one of the highlights of this institution," the Dean said.



The Committee on Scientific Publications met recently to map editorial plans for the coming year. Among those present were members of the new Editorial Board of *The Journal*, including (left to right) Edward Pedrero Jr., M.D., of Tampa, Assistant Editor; F. Norman Vickers, M.D., of Pensacola, Book Review Editor; E. Charlton Prather, M.D., of Tallahassee, Associate Editor; Daniel B. Nunn, M.D., of Jacksonville, Editor; Clyde M. Collins, M.D., Jacksonville, Associate Editor; and Lee A. Fischer, M.D., of West Palm Beach, Assistant Editor. Members of the Editorial Board not pictured are Assistant Editors James K. Conn, M.D., Tallahassee; J. Lee Dockery, M.D., of Gainesville; and Historical Editor William M. Straight, M.D., of Miami.

ORGANIZATION



George S. Palmer, M.D., former Executive Director of the Florida State Board of Medical Examiners, displays a plaque presented to him by the Board in appreciation for his services. First row: Ms. Dorothy J. Faircloth, current Executive Director of the BME; Dr. Palmer; Dana V. Wallace, M.D., Fort Lauderdale; and Richard T. Conard, M.D., Bradenton. Second row: Raul Valdes-Fauli, Esq., Miami; Robert B. Katims, M.D., Board Chairman, Miami; Alberto Hernandez, M.D., Miami; Ben M. Cole, M.D., Orlando; Richard J. Feinstein, M.D., Miami; and Robert N. Webster, M.D., Board Vice Chairman, Tallahassee.

Dr. George S. Palmer Honored for Service As BME Executive Director

George S. Palmer, M.D., Executive Director of the Florida State Board of Medical Examiners for 13 years until leaving the post last April, was honored by Board members at their meeting at Bal Harbour on June 7.

Dr. Palmer was presented with a plaque in observance of his service. The text stated:

"In recognition of his dedicated and devoted service to all the citizens and physicians of Florida while serving as the Director of the State's Board of Medical Examiners."

Prior to assuming the Executive Directorship of the Board in 1967, Dr. Palmer was a member of the Board and maintained a private pediatric practice in Tallahassee. He is a former President of the Florida Medical Association.

Dr. Palmer is now Medical Consultant to the Florida Department of Professional Regulation, parent agency of the Board of Medical Examiners.

Malpractice

St. Paul lawyers, who defend many physicians in our state, have found a startling trend in many suits filed in South Dakota. More suits are instigated due to the fact that one physician criticizes a physician or insinuates that the previous physician treated the patient improperly. I would never suggest that we condone poor treatment that injures a patient. However, it is unconscionable, and perhaps unethical, to criticize a fellow physician's treatment without first ascertaining all of the facts.

D. B. Reaney, M.D., President
South Dakota State Medical Association



Correspondence

CONTROLLED STUDY SUBJECTS SOUGHT

To the Editor: During the last four years, I have treated two patients with Paget's disease of bone with biweekly injections of calcium gluconate intravenously. The results in both instances have been dramatic improvement in the patient's subjective symptoms and presumed arrest of the disease. We would appreciate any information concerning patients who would possibly be available for a controlled study of intravenous calcium gluconate therapy for Paget's disease of bone.

Please contact me at the Division of Renal Medicine, Box J-224, JHMHC, University of Florida, Gainesville, Florida, 32610. Thank you.

J. Robert Cade, M.D.
Professor of Medicine
Division of Renal Medicine

FLAMPAC IS READY

To the Editor: The Florida Medical Political Action Committee (FLAMPAC) is one of the oldest political action committees in Florida. The current organization, chartered in 1962, grew from the original Florida Physicians for Better Government which was formed in 1950. Governed by a nine member Board of Directors, the campaign and political education activities of FLAMPAC are primarily carried out by a national and a state candidate advisory board. These are composed of auxiliary and M.D. representatives from each of Florida's medical and congressional districts, whose principal responsibilities are to coordinate the programs of FLAMPAC with those of local physicians and their wives and to advise the Board on candidates seeking state and national office.

Contrary to some media reports, FLAMPAC does not become involved in legislative issues. The purpose of FLAMPAC is to provide a legal and effective vehicle for physicians and their families to participate in the political process. The objectives of FLAMPAC are:

> To promote and strive for the improvement of government by encouraging and stimulating physicians and others to take a more active and effective part in governmental affairs.
>
> To encourage physicians and others to understand the nature and actions of their government, as to important political issues, and as to the records of office holders and candidates for elective office at all levels of government.
>
> To assist physicians and others in organizing themselves for more effective political action and in carrying out their civic responsibilities.

The candidate selection process is a sophisticated activity that is primarily based upon the recommendations of local physicians and their wives. FLAMPAC generates support only for candidates for state or national office that have the support of, and recommendations from, their local physician community. These recommendations and analyses are presented to the FLAMPAC Board by the members of the Candidate Advisory Boards for State and National Elections. In making a determination for candidate support, the FLAMPAC Board uses the following general criteria:

> The candidate's reputation, honesty, behavior, character, willingness to work for the job, ability to speak, the ability and willingness to listen objectively and support from the physicians in the district.

Consistent with the above process, FLAMPAC contributed to 133 candidates during the 1978 Elections. With an overall success rate of 81%, FLAMPAC was on the winning side 80% of the time in congressional races, 82% in State Senate races, and 80% of the time in races for the Florida House of Representatives. This parallels the experience for the last several election periods.

With new and increased challenges facing the medical community for the 1980s, the FLAMPAC Board has adopted an aggressive program for increased involvement of physicians and their families in Florida's political campaigns. This will involve improved communi-

cation with FLAMPAC members, training seminars for candidate evaluation and support and availability of FLAMPAC field staff during the election period.

To accomplish these goals, an increase in FLAMPAC membership is necessary. A minimum goal of 6,000 members for 1980 has been established, with special emphasis being placed on solicitation of sustaining members.

Suggested annual membership dues are:

Individual $40. (FLAMPAC $30. — AMPAC $10.)
Sustaining $100. (FLAMPAC $50. — AMPAC $50.)

Your support of FLAMPAC will help insure that the medical profession is an effective participant in the political process. Please resolve now to commit of your time and resources to this critical program during the coming year.

A copy of our report is filed with the Federal Election Commission and is available for purchase from the Federal Election Commission, Washington, D.C.

Francis C. Coleman, M.D
President
Florida Medical Political Action Committee
Tampa

M.D.'S AND SCHEDULE II DRUGS

Dr. Harold Parham, Executive Vice President
Florida Medical Association
Jacksonville

Dear Dr. Parham: On June 6, 1980 the House passed CS/HB 924 as an amendment to SB 1221 which will be of great value to those Medical, Osteopathic and Pharmaceutical Societies who are currently conducting voluntary control programs for some Schedule II drugs or who may contemplate such a program in the future.

One of the problems has been the reluctance on the part of the pharmacists to keep a list of physicians prescribing Schedule II drugs and then reporting them to the Medical Societies because of the fear of possible suit for libel that might be brought by a physician against a pharmacist. This law provides "immunity to members of a duly appointed Medical Review Committee or any health care providers furnishing any information to such a Committee" as long as the information is provided without malice or fraud.

We have also requested 12 new inspectors for the Department of Professional Regulation to assist the Secretary in carrying out the disciplinary actions of the new practices statutes.

David J. Lehman, M.D.
Representative District 97

WHAT OTHERS WERE DOING — 1923

(Editor's note: The following exchange was brought to our attention by a friend of *The Journal*. It seems appropriate for inclusion in this Historical Issue. Misspelled words have been left unchanged to retain accuracy.)

Louisville & Nashville Railroad Company
Pensacola Division
Office of the Superintendent

Pensacola, Fla., July 6, 1923
811-35

Dr. J. K. Turner,
Milton, Florida

Dear Sir:

With reference to the position of local surgeon at Milton, Florida.

I now have Dr. Nowling's resignation. It has been concluded to appoint you surgeon for this company at Milton, Fla. and I enclose fee blank in duplicate. Will you be kind enough to execute and return one copy, retaining the other for your information and file?

Yours truly,
Superintendent

Fees for Professional Services and Regulations Covering Physicians and Surgeons not Salaried, When Employed by the Railroad Co.

$3 — Three dollars will be allowed for the first visit in minor surgical operations, such as are required for contused, incised, or lacerated wounds, burns, scalds, etc., or the introduction of catheter.

$5 — Five dollars will be allowed for the first visit: if one or more fingers are amputated; if fracture of the bones of the hand or feet are treated; if dislocation of any of the bones of the hands or feet is reduced; if any artery below the knee or elbow joint is ligated in open wound.

$1 — One dollar for each subsequent visit.

$10 — Ten dollars will be allowed for the first visit: if dislocation of the shoulder, elbow, wrist, knee, ankle, or

jaw is reduced; if fracture of the fumur, scapula, fibula, patella or clavicle is treated; if fracture of the leg, arm, forearm, or either jaw is treated. In reducing compound or comminuted fractures of the arm or of the leg 25 per cent will be added.

$20 — Twenty dollars will be allowed for trophining skull.

$30 — Thirty dollars will be allowed for the first visit: if amputation at knee joint of leg, feet, arm, or forearm is performed; for excision of any of the larger joints, except hip-joints; if an artery below elbow or knee joint is ligated (not in open wound).

$1 — One dollar for each subsequent visit.

$40 — Forty dollars will be allowed for the first visit: if amputation of the hip or shoulder joint, or excision of the hip joint is performed; if dislocation of the hip joint is reduced; if amputation of the thigh is performed.

$1 — One dollar for each subsequent visit.

For services not above enumerated the company will pay lowest local rates, less 25 per cent. Surgeons will be allowed compensation for any unusual expenses incurred in the care of the injured. If the patient is at a distance from where the physician or surgeon resides ten cents per mile additional will be allowed in one direction only. If the party injured comes to the surgeon's office and he is there treated, in the same locality, and at the same visit, charge will be made for all over one as if they were treated in the physicians office; if any party supposed to be injured, upon examination does not require medical or surgical treatment, the surgeon shall charge a medical fee if the patient has received more than one injury charge will be made for the most serious one, and that only. The surgeon will furnish without charge instruments, anesthetics, splints, medicines, or anything necessary for the performance of any operation, treatment or fracture of dressing wounds. No additional charge will be made for night visits. No charge will be made for unnecessary visits. No charge will be made for extraordinary attention. When assistance is necessary one third the above rates may be paid.

It is hereby understood and agreed that the undersigned when employed by the L. & N. R. R. Company agrees to be governed by the above fee bill and regulations.

Signed _____

Address _____

Graduate of _____

SECOND OPINION ON SECOND OPINIONS

To the Editor: I enjoyed the article on Second Opinions by Dr. James F. Richards Jr. (JFMA 67:6, p. 569) and found it to be thorough and very informative. I have recommended it be distributed to the Blue Cross and Blue Shield Boards of Directors, particularly for the benefit of the nonphysicians to whom I believe this article would be specifically beneficial.

Charles P. Hayes Jr., M.D.
Jacksonville

AMA Schedules CME Meetings In Seven Locations

The American Medical Association Council on Continuing Physician Education has announced seven continuing medical education meetings between now and November.

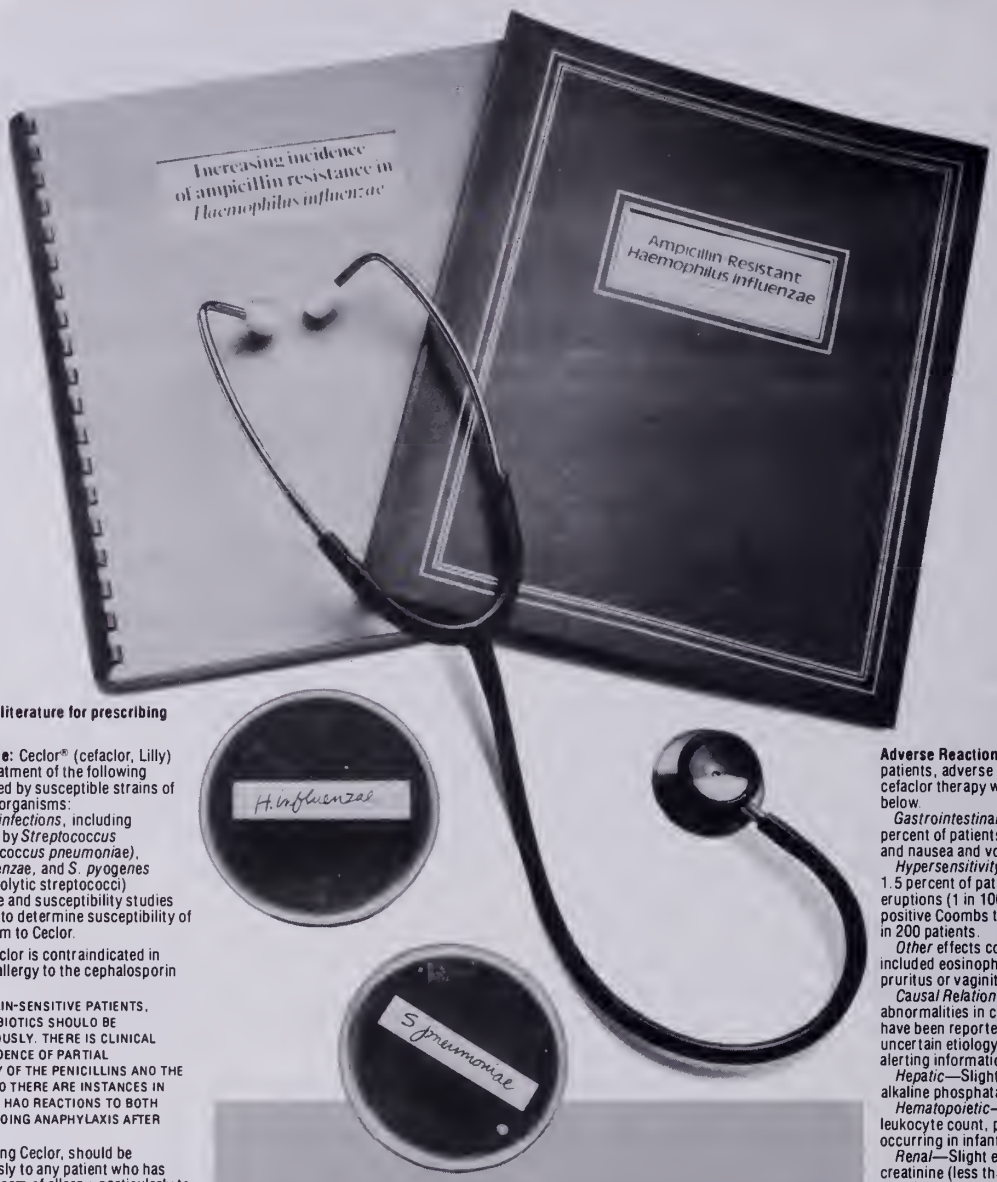
Among them will be a theme meeting on "Drugs in Medical Practice, 1981: A Critical Review and Workshop," co-sponsored by the American Society of Clinical Pharmacology and Therapeutics. It will be conducted in Kansas City, Mo., September 27-28.

Regional meetings on the schedule include:

Cape Cod, Mass., September 12-14; Chicago, September 19-21; Huron, Ohio, October 17-19; Philadelphia, October 24-26; New York, November 14-16; and San Antonio, Texas, November 16-19.

Information is available from Gale Jewett, Council on Continuing Physician Education, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

An added complication... in the treatment of bacterial bronchitis*



Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

Ceclor®
cefaclor

Pulvules®, 250 and 500 mg

Brief Summary.
Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae)*, *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER PARENTERAL USE).

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefaclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

Usage in Pregnancy—Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy—Safety of this product for use in infants less than one month of age has not been established.

Adverse Reactions: In clinical studies in 1493 patients, adverse effects considered related to cefaclor therapy were uncommon and are listed below.

Gastrointestinal symptoms occurred in about 2.5 percent of patients and included diarrhea (1 in 70) and nausea and vomiting (1 in 90).

Hypersensitivity reactions were reported in about 1.5 percent of patients and included morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs tests each occurred in less than 1 in 200 patients.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory tests results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200). [070379R]

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

Note: Ceclor® (cefaclor) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

References

1. Antimicrob. Agents Chemother., *8*:91, 1975.
2. Antimicrob. Agents Chemother., *11*:470, 1977.
3. Antimicrob. Agents Chemother., *13*:584, 1978
4. Antimicrob. Agents Chemother., *12*:490, 1977.
5. Current Chemotherapy (edited by W. Siegenthaler and R. Luthy), II: 880. Washington, D.C.: American Society for Microbiology, 1978.
6. Antimicrob. Agents Chemother., *13*:861, 1978.
7. Data on file, Eli Lilly and Company.
8. Principles and Practice of Infectious Diseases (edited by G.L. Mandell, R.G. Douglas, Jr., and J.E. Bennett), p. 487. New York: John Wiley & Sons, 1979.

Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285

Eli Lilly Industries, Inc.
Carolina, Puerto Rico 00630

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FMA AUXILIARY

Auxiliary's Future

As Florida's national representative, I have been appointed by the President of the AMA Auxiliary to the Resident Physician/Medical Student Spouse Committee (RP/MSS) for the Southern Region. This is a comparatively new committee consisting of a National Chairman and four Regional Chairmen whose prime objective is to recruit and retain these spouses for Auxiliary membership. To achieve this objective, we are working very closely with all Auxiliary, medical student and resident physician leaders. Further, we are requesting every state and county where teaching institutions are located to appoint a RP/MSS liaison.

The FMA Auxiliary's liaison is Mrs. Laurin Smith, who has worked diligently this past year in this capacity. National dues are $3.00 a year, with state and county dues left to the discretion of the individual Auxiliary.

Some membership benefits include: participation in free leadership training and educational seminars, constructive involvement with health care by impacting legislation and receipt of publications including "Facets", the AMA Auxiliary's official publication plus "Horizons", a newsletter especially geared to the RP/MSS. We are encouraging all auxiliaries to invite these spouses to participate and to direct specific programs to their interests. The National Auxiliary has material available for such programs.

One excellent resource is National's "Project Bank", a unique clearing house for community health programs and projects. There are now approximately 40,000 resident physician and medical student members of the AMA and only 200 Auxiliary members. As is evident, more effort can and must be expended to interest and ultimately secure these vital spouses. They are Auxiliary's life-line. We need their talents and energy. They need our support and encouragement. Together we are invincible!

Mrs. B. David Epstein
RP/MSS Southern Regional
Membership Chairman for
the AMA Auxiliary 1980-1981

Fifty Years Ago

In *The Journal of the Florida Medical Association* for August 1930:

The manufacturer of Listers Flour offered for $4.85 a month's supply of its product advertised as a "strictly starch-free" base for "palatable muffins, bread, cakes, pastry, etc." . . . The scientific section included a paper on "The Responsibilities of the Railway Surgeon" contributed by **Harold D. Van Schaick, M.D.**, of Jacksonville . . . **Henry E. Palmer, M.D.**, of Tallahassee, wrote on "Spider Poisoning" and **Rufus J. Pearson, M.D.**, of Miami, contributed an article on "Local Anesthesia in Tonsillectomy" . . . **Dr. and Mrs. H. Quillian Jones** of Fort Myers recently returned from a motor trip to Detroit and Chicago, where they attended the annual conventions of Rotary and the American Medical Association . . . Among physicians passing the Florida licensing examination in Lakeland the previous June was **Duncan T. McEwan, M.D.**, of Orlando, who a quarter-century later became President of the Florida Medical Association . . . A meeting of the Escambia County Medical Society to discuss malpractice insurance was held on July 15 . . .

And so it was in Florida medicine 50 years ago this month. — E.D.H.

Magic at HEW: How 145,000 Workers Became 1,126,000

On paper, the Department of Health, Education and Welfare (now Health and Human Services) in 1978 carried a payroll of 145,000 workers. But the number of people actually supported by that agency — subsequently it was split into two departments — was more than six times as large. Former HEW Secretary Joseph Califano provided Congress with this breakdown.

Workers supported by HEW grants and contracts —

In local governments	572,700
In state governments	84,000
At universities	87,700
At research institutions	33,400
With private contractors	113,900
Others	88,900

Thus, the "hidden work force" amounts to 981,200 above and beyond the 145,000 that HEW employs directly. Department's total force: 1,126,000 in all.

U.S. News & World Report (Feb. 18, 1980)

SEXTO SEMINARIO MEDICO PANAMERICANO
Noviembre 10-14, 1980

Totalmente en Espanol

Director del Seminario: FEDERICO R. JUSTINIANI, M.D.

Profesores:

GERMAN CASAL, M.D.
CARLOS J. DOMINGUEZ, M.D.
ENRIQUE GORIN, M.D.
ENRIQUE HANABERGH, M.D.
JOSE F. LANDA, M.D.
JUAN-MARTIN LEBORGNE, M.D.
ALFREDO LOPEZ-GOMEZ, M.D.
LUIS O. MARTINEZ, M.D.
JORGE MORDUJOVICH, M.D.
JOHN NIVEN, M.D.
SIMON ROZEN, M.D.
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MANUEL VIAMONTE, JR., M.D.
MARIA VIAMONTE, M.D.

Mount Sinai
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CONFERENCIAS SOBRE:

NEFROLOGIA
CANCER DEL SENO
ECOCARDIOGRAFIA
ARRITMIAS CARDIACAS
INFECCIONES Y ANTIBIOTICOS
ENFERMEDADES PULMONARES INTERSTICIALES
RADIOLOGIA DIAGNOSTICA

HORARIO:

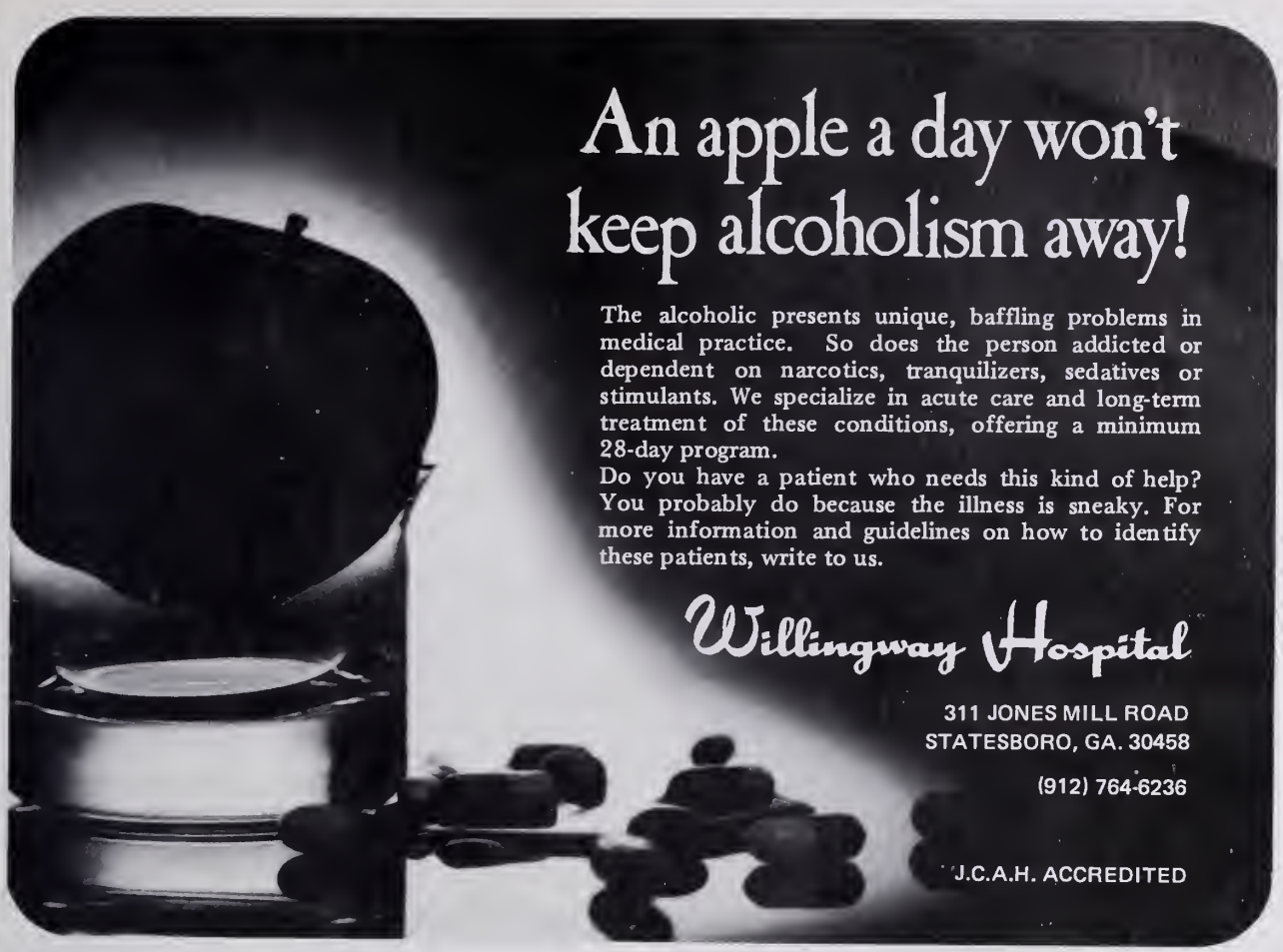
9:00 AM-1:00 PM
(Lunes a Viernes)

3:00 PM-5:00 PM
(Lunes a Jueves

CUOTA DE INSCRIPCION: $180 (incluye derecho de asistencia a las sesiones cientificas, certificado, coleccion de la grabacion de las conferencias y banquete de clausura).

Este seminario esta aprobado para 23 horas Prescritas por la AAFP; para 23 horas Mandatorias por la FMA y para 23 horas en la Categoria I por la AMA para el "Physician's Recognition Award".

Para mas informacion e inscripcion dirijase a: Continuing Medical Educaion
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An apple a day won't keep alcoholism away!

The alcoholic presents unique, baffling problems in medical practice. So does the person addicted or dependent on narcotics, tranquilizers, sedatives or stimulants. We specialize in acute care and long-term treatment of these conditions, offering a minimum 28-day program.

Do you have a patient who needs this kind of help? You probably do because the illness is sneaky. For more information and guidelines on how to identify these patients, write to us.

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J.C.A.H. ACCREDITED

When
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is due to androgenic deficiency.

Android®-5 (Buccal) **-10** (Oral) **-25** (Oral)
Methyltestosterone U.S.P. Tablets

A well absorbed oral androgen.

Additional indications: Replacement therapy. When androgen deficiency is the cause of: male climacteric/eunuchoidism, eunuchism/post-puberal cryptorchidism.



DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, heve been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosege of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testiculer function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metestases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia **DOSAGE AND ADMINISTRATION:** Dosege must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg., Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D., R. Witherington, M.D., I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climecteric. *Drug Therepy*, Sept. 1976 **SUPPLIED:** 5, 10, 25 mg. In bottles of 60, 250. Rx only

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Treat the symptoms in the geriatric patient

apathy
irritability
forgetfulness
confusion

Cerebro-Nicin®
CAPSULES

A gentle cerebral stimulant and vasodilator for the geriatric patient

Each CEREBRO-NICIN® capsule contains:
Pentylenetetrazole ..... 100 mg.
Nicotinic Acid ..... 100 mg.
Ascorbic Acid ..... 100 mg.
Thiamine HCL ..... 25 mg.
l-Glutamic Acid ..... 50 mg.
Niacinamide ..... 5 mg.
Riboflavin ..... 2 mg.
Pyridoxine HCL ..... 3 mg.

AVAILABLE: Bottles 100, 500, 1000

SIDE EFFECTS: Most persons experience a flushing and tingling sensation after taking a higher potency nicotinic acid. As a secondary reaction some will complain of nausea, sweating and abdominal cramps. The reaction is usually transient.

INDICATIONS: As a cerebral stimulant and vasodilator.

RECOMMENDED GERIATRIC DOSAGE: One capsule three times daily adjusted to the individual patient.

WARNING: Overdosage may cause muscle tremor and convulsions.

CONTRAINDICATIONS: Epilepsy or low convulsive threshold.

CAUTION: Federal law prohibits dispensing without prescription. Keep out of reach of children.

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MEETINGS

Accepted by the FMA Committee on Continuing Medical Education for Mandatory Credit

SEPTEMBER

Electrophysiology of the Heart, Sept. 3-5, Mount Sinai Medical Center, Miami. For information: CME Office, Philip Samet, M.D., Mount Sinai Medical Center, 4300 Alton Road, Miami 33140.

Sixth Cardiovascular Symposium, Sept. 4-5, Gainesville Hilton, Gainesville. For information: Howard W. Ramsey, M.D., 1131 N.W. 64th Terrace, Gainesville 32605.

Dermatology in Florida, Sept. 8, Citrus Memorial Hospital, Inverness. For information: R. Edward Dodge Jr., M.D., 511 W. Highland Blvd., Inverness 32650.

Medical-Legal Concepts in Medical Liability, Sept. 12-14, Court of Flags Hotel, Orlando. For information: Lionel H. Blackman, M.D., 1665 Palm Beach Lakes Blvd., Suite 502, West Palm Beach 33401.

Neurology for Neurologists, Sept. 25-27, Palm Beach. For information: Stephen A. Shaivitz, M.D., 3701 Broadway, West Palm Beach 33407.

OCTOBER

Advanced Cardiac Life Support Course, Oct. 3-4, Hollywood Medical Center, Hollywood. For information: Karen R. Craparo, M.D., Chief Emergency Room Physician, Hollywood Medical Center, 3600 Washington Street, Hollywood 33021.

Echocardiography In-Service Workshop, Oct. 20-24, University of Miami, Jackson Memorial Medical Center, Miami.*

Sexual Problems in Everyday Practice, Oct. 29-30, Mount Sinai Medical Center, Miami Beach. For information: CME Office, Ronald H. Scheer, M.D., Mount Sinai Medical Center, 4300 Alton Road, Miami Beach 33140.

21st Workshop in EKG for Nurses and Physicians, Oct. 30-Nov. 3, Sheraton Sand Key Hotel, Clearwater Beach. For information: Henry J. L. Mariott, M.D., St. Anthony's Hospital, St. Petersburg 33705.

NOVEMBER

Difficult Decisions in Cancer Management, Nov. 1, Holiday Inn, (Sarasota) Longboat Key. For information: S. P. Bralow, M.D., 1814 Hillview Street, Sarasota 33579.

Fourth Annual Suncoast Perinatal Conference, Nov. 7-8, Bayfront Medical Center, St. Petersburg. For information: Mrs. Pat Fowler, Bayfront Medical Center, 701 Sixth St. S., St. Petersburg 33701.

Vascular Lesion of CNS, Nov. 10, Citrus Memorial Hospital, Inverness. For information: R. Edward Dodge Jr., M.D., 511 W. Highland Blvd., Inverness 32650.

Sixth Annual Pan American Medical Seminar, (In Spanish), Nov. 10-14, Mount Sinai Medical Center, Miami Beach. For information: CME Office, Federico R. Justiniani, M.D., Mount Sinai Medical Center, 4300 Alton Road, Miami Beach 33140.

Hypertension Workshop, Nov. 13, Abbey Hospital Conference Room, Coral Gables. For information: Anthony J. Pellicane Sr., M.D., 5190 S.W. 8th St., Coral Gables 33134.

***For information: Contact Division of Continuing Medical Education, D23-3, University of Miami School of Medicine, P.O. Box 016960, Miami 33101. Tel. (305) 547-6716.**

****For information: Contact Division of Continuing Education, Box J-233, J. Hillis Miller Health Center, Gainesville 32610. Tel. (904) 392-3143, or 392-3183.**

+For information: Contact Janifer M. Judisch, M.D., CME, University of South Florida, Tampa 33620. Tel. (813) 974-2196.

MARK THESE DATES ON YOUR CALENDAR!!!!!!

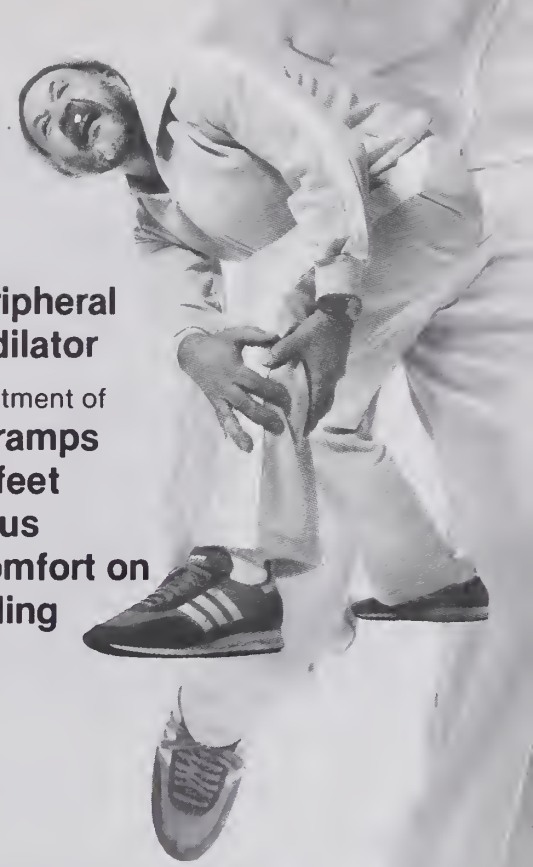
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Category I AMA accreditation—7 credit hours
Registration Fee—$35. for Practicing Physicians.
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OCTOBER 29 and 30, 1980
SEXUAL PROBLEMS IN MEDICINE—
Category I AMA accreditation—12 credit hours.
Registration Fee—$50. for Practicing Physicians
Guest Faculty will include MASTERS/JOHNSON.

NOVEMBER 10-14, 1980
SIXTH ANNUAL PAN AMERICAN MEDICAL SEMINAR
Category I AMA accreditation—23 credit hours
Registration Fee $180. for Practicing Physicians.
FEDERICO R. JUSTINIANI, M.D.—
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TOTALLY IN SPANISH

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A peripheral vasodilator

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Nicotinic Acid Therapy

For patient's
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3 strengths

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Each time-release capsule contains:
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in a special base of prolonged therapeutic effect.
DOSE: 1 to 2 tablets daily.
AVAILABLE: Bottles of 100, 500.

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LIPO-NICIN®/250 mg.
Each yellow tablet contains:
Nicotinic Acid .....250 mg.
Niacinamide.....75 mg.
Ascorbic Acid.....150 mg.
Thiamine HCL (B-1) .....25 mg.
Riboflavin (B-2).....2 mg.
Pyridoxine HCL (B-6) .....10 mg.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500.

LIPO-NICIN®/100 mg.
Each blue tablet contains:
Nicotinic Acid .....100 mg.
Niacinamide.....75 mg.
Ascorbic Acid.....150 mg.
Thiamine HCL (B-1) .....25 mg.
Riboflavin (B-2).....2 mg.
Pyridoxine HCL (B-6) .....10 mg.
DOSE: 1 to 5 tablets daily.
AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN® 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient.

Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur.

Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

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Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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SEPTEMBER 1980 • VOL. 67 • NO. 9



SEP 23 1980

SPECIAL ISSUE ON FAMILY PRACTICE

Cranford O. Plyler, Jr., M.D., Guest Editor

half-life

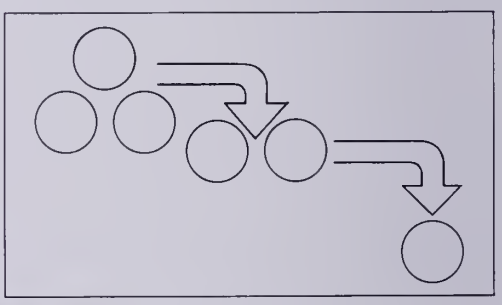
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***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies Observe usual precautions in impaired renal or hepatic function Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported, should these occur, discontinue drug Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy

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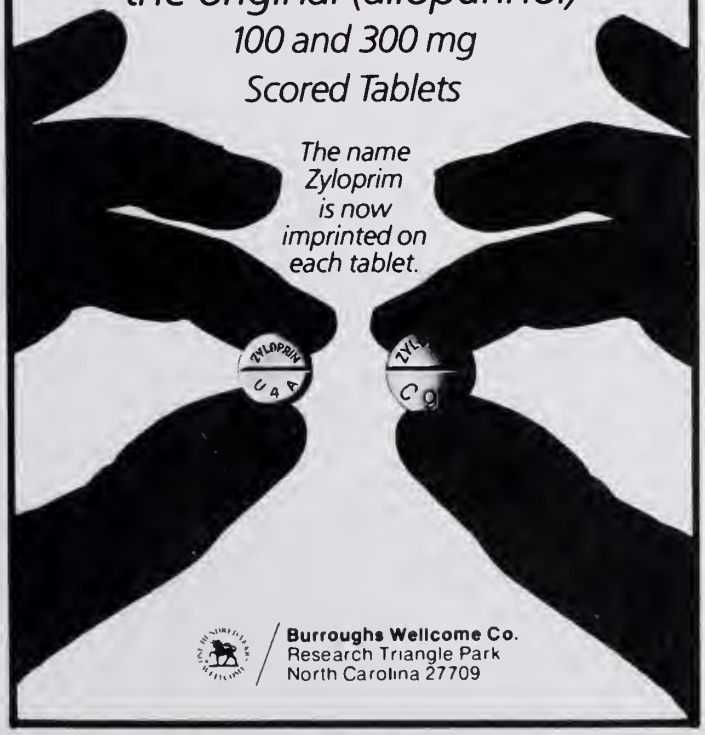
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We are indebted to Dr. Cranford O. Plyler Jr., of Jacksonville, and the Florida Academy of Family Physicians for bringing this special issue to our readers. We are most grateful to the authors and contributors to this issue of The Journal. (See contents on opposite page).

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The cover, a collage depicting the scope of family practice, was created by Nicholas S. Petkas, M.D., a family physician of Lake Park, Florida. Dr. Petkas has been a member of the American Academy of Family Physicians and the Florida Academy of Family Physicians since 1960. He is a Diplomate of the American Board of Family Practice. In addition to art, Dr. Petkas' hobbies include wood carving and gem cutting.

Special Issue
Family Practice

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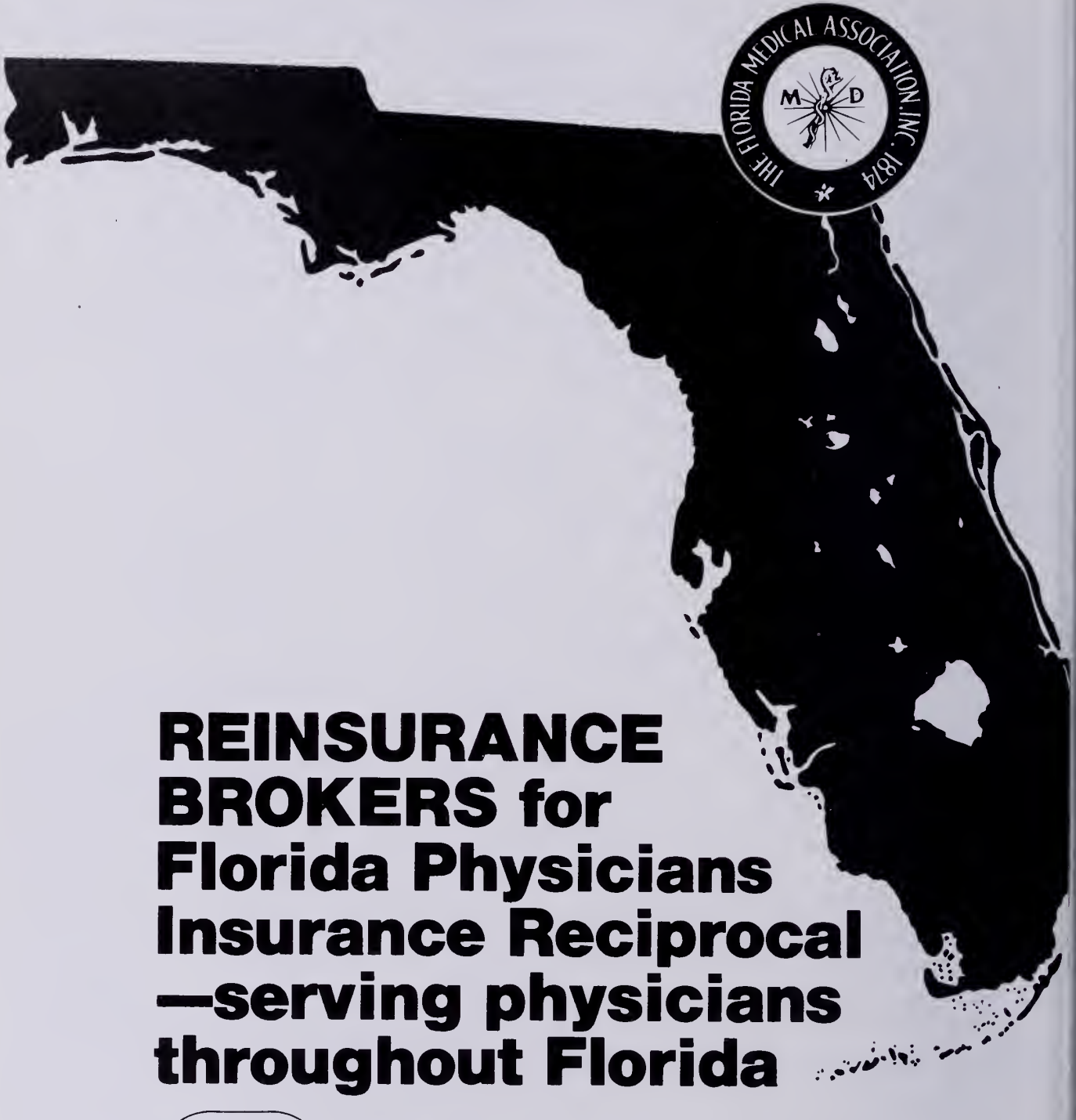
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Professional Liability Legal Update

Informed Consent - Pap Smear

Two children brought this wrongful death action against a doctor for his failure to perform a pap smear on their mother, who died of cancer of the cervix. Expert testimony at trial established that if the mother had undergone a pap smear at any time between 1964 and 1969, the cervical tumor probably would have been discovered in time to save her life. The defendant doctor testified that on at least two occasions when he performed pelvic examinations of the mother, she refused him permission to perform the pap smear test, stating that she could not afford the cost. The issue presented to the court was whether the doctor breached his duty of care to the patient when he failed to inform her of the potentially fatal consequences of allowing cervical cancer to develop undetected by a pap smear test.

The doctor contended that the duty to disclose applies only where the patient consents to the recommended procedure. He argued that since a physician's advice may be presumed to be founded on an expert appraisal of the patient's medical needs, no reasonable patient would fail to undertake further inquiry before rejecting such advice. Therefore, patients who reject their physician's advice should shoulder the burden of inquiry as to the possible consequences of their decision. The court rejected the doctor's contention, holding that a physician recommending a "risk-free" procedure may safely forego discussion beyond that necessary to conform to competent medical practice and to obtain the patient's consent. If a patient indicates that he or she is going to decline the risk-free test or treatment, then the doctor has the additional duty of advising of all material risks of which a reasonable person would want to be informed before deciding not to undergo the procedure. If the recommended test or treatment is itself risky, then the physician should always explain the potential consequences of declining to follow the recommended course of action.

The court, likewise, rejected the doctor's contention that, as a matter of law, he had no duty to disclose to the patient the risk of failing to undergo a pap smear test because the danger was remote and commonly appreciated to be remote. It was felt that under the evidence presented, a jury could reasonably conclude that the doctor had a duty to inform the patient of the danger of refusing the test because it was not reasonable for the doctor to assume that the patient appreciated the potentially fatal consequences of her conduct.

It was held that the lower court erred in failing to instruct the jury that it is the duty of a physician to disclose to his patient all relevant information to enable the patient to make an informed decision regarding the submission to, or refusal to take a diagnostic test. Failure of the physician to disclose to his patient all relevant information including the risks to the patient, if the test is refused, renders the physician liable for any injury legally resulting from the patient's refusal to take the test if a reasonably prudent person in the patient's position would not have refused the test if she had been adequately informed of the significant perils.

In dissent, two judges expressed the opinion that "the consent instructions approved by the majority will impose upon doctors the intolerable burden of having to explain diagnostic tests to healthy patients. To meet their new burden, doctors will have to spend a greater part of their day not examining or treating patients, but explaining to them all information relevant to the purposes of diagnostic tests. Moreover, the physician-patient relationship is based on trust and forcing the doctor into a hard sell approach to his services can only jeopardize that relationship." (Truman v. Thomas, Cal. Sup. Ct., June 9, 1980)

Recognition of Brain Death

During the 1980 Legislative Session, legislation was enacted which prohibits civil or criminal proceedings against a physician or licensed medical facility that declares a patient to be dead, if the determination of

Prepared and submitted by John E. Thrasher, J.D., Vice President and Legal Counsel, and Anthony J. McNicholas III, J.D., Associate Legal Counsel, Professional Insurance Management Co. (PIMCO), Jacksonville, Florida.

death is made in accordance with the newly-adopted statutory provisions. The Act, effective October 1, 1980, provides that for legal and medical purposes, where respiratory and circulatory functions are maintained by artificial means of support so as to preclude a determination that these functions have ceased, the occurrence of death may be determined where there is the irreversible cessation of the functioning of the entire brain, including the brain stem. Determination of death pursuant to the Act must be made in accordance with currently accepted reasonable medical standards by two physicians. One physician must be the treating physician, and the other physician must be a board eligible or board certified neurologist, neurosurgeon, internist, pediatrician, surgeon or anesthesiologist. The Act further provides that the next of kin of the patient must be notified as soon as practicable of the procedures to determine death under the Act. The medical records must reflect such notice, and if notice has not been given, the medical records must reflect the attempts to identify and notify the next of kin. Section 382.085, Florida Statutes (1980).

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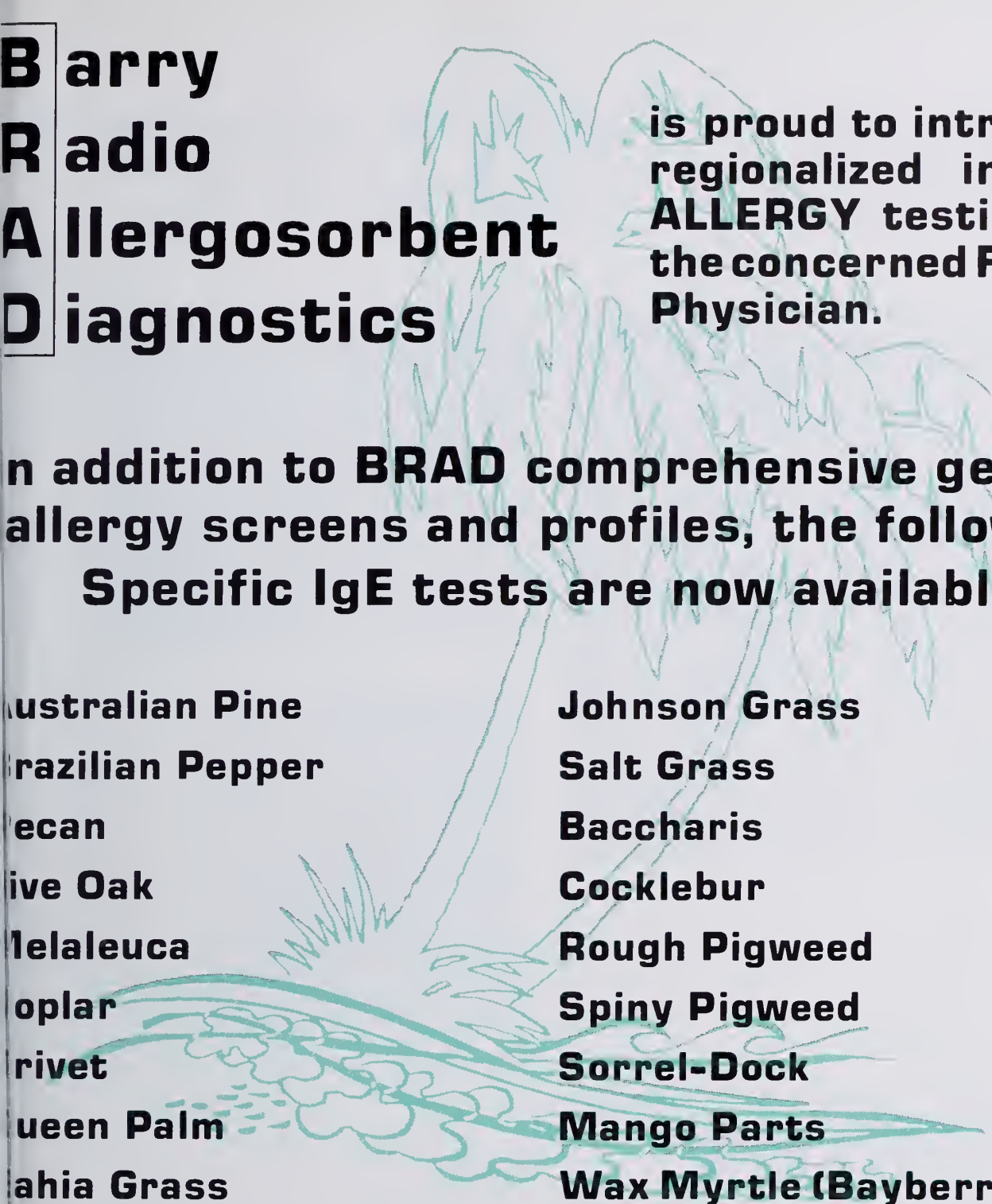
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Editorial

Reflections on the Annual AMA Meeting

It was another July scorcher when I boarded the plane in Jacksonville enroute to the Windy City and the Annual Meeting of the American Medical Association. As I glanced about the cabin I found myself in the company of an AMA Delegate, FMA Staff Executives, and three comely Auxilians. Naturally I opted for a seat among the ladies who by virtue of their charm and intellect soon transformed a tedious flight into a most enjoyable experience. I was duly impressed with their serious discussions of Auxiliary issues, but equally amused when a dietary convert of the group punctuated conversations by proffering low calorie snack foods. "Crunches" were particularly memorable since I imagined the taste being similar to a Gaines product which makes its own gravy with a little H_2O.

At both the airport and the two hotels housing the AMA and Auxiliary conventions I encountered increasing numbers of FFF (Familiar Florida Faces). Ultimately I noted a Florida contingent totalling 52 persons. This included 14 AMA Delegates and Alternates; an AMA Past President (Ed Annis); two representatives of national specialty societies; FMA Secretary Bob Windom; a medical student from USF; and 17 Auxiliary Delegates, one of whom (Connie Moore) occupies a position on the AMPAC Board.

For the Florida group each day of the AMA meeting began with a 7 a.m. caucus. As a matter of fact, the early starting time coupled with extenuating circumstances (my location at the "Auxiliary hotel" several blocks away, a 2 a.m. emergency visit to repair with adhesive tape the cut eyelid of a nameless Auxilian, and an unexpected pre-dawn call from a colleague in Atlanta) precluded any plans I might have had for a restful trip. The first caucus held in conjunction with the Southeastern Delegation(a coalition of Southeastern states of which Florida is a member) featured the candidates for President Elect of the AMA, the Board of Trustees, and membership on various councils. In general, the candidates appeared knowledgeable and presented themselves well; all deserved accolades for their interest and willingness to serve.

During the course of the AMA sessions, which covered a five day period, I witnessed an impressive display of parliamentary manuevering and debate. Indeed, it was remarkable that the House of Delegates with the assistance of Reference Committees considered 249 items. Amid such activity the highlight seemed to be the adoption of a new code of medical ethics. This was a culmination of a two year study by an ad hoc committee, and represented the first revision of ethical principles approved in 43 years. With respect to National Health Insurance, the Association reaffirmed its policy to "continue to advocate in a positive manner the superiority of a voluntary, free-choice method of medical and health care delivery compared to a system dominated and controlled by the Federal government." The current emphasis is to work within the principles outlined by Florida Resolution 62 to assure the availability of private insurance against the cost of catastrophic illness.

It is noteworthy that our own Delegation made significant contributions to the 1980 meeting. The Delegates offered resolutions to 1) establish national drug abuse programs for the control of amphetamines and methaqualones; 2) educate the public as to the hazards of cigarette smoking emphasizing the economics of the medical problems created; 3) oppose the use of governmental funds to promote the enrollment of Medicare beneficiaries in HMOs over other forms of health care delivery; and 4) oppose the implementation of federal regulation 42 CFR 405 relating to Medicare reimbursement to hospital based physicians. In addition to these efforts, Dick Connar served us well in the Council on Medical Education, Rufus Broadaway performed admirably as Chairman of Reference Committee C, and Joe Von Thron participated enthusiastically in the floor debate on National Health Insurance. As a matter of interest, the Delegates unanimously decided to

nominate Rufus, who is also a Registered Parliamentarian and member of the AMA's Long Range Planning Committee, for the office of Vice Speaker next year.

This was my first AMA meeting and admittedly I embarked upon the venture with a great deal of curiosity and some degree of skepticism. In the end, however, I came away convinced that the AMA is a democratic professional organization truly dedicated to the highest standards for medical education, medical care, and medical ethics. Moreover, it is important to recognize that the AMA is the largest, best financed, and broadest-based entity within organized medicine. We would be wise to give the AMA our full support.

Daniel B. Nunn, M.D.
Editor



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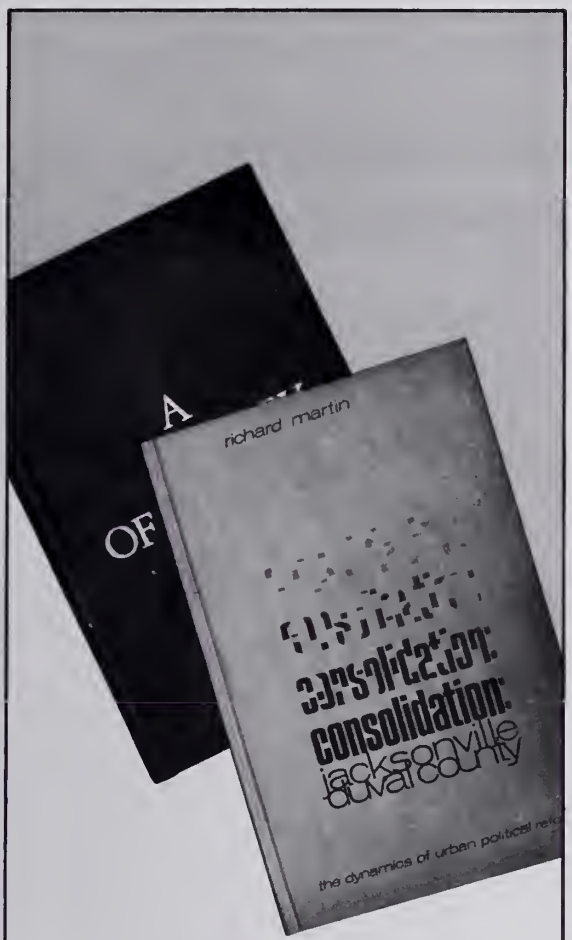
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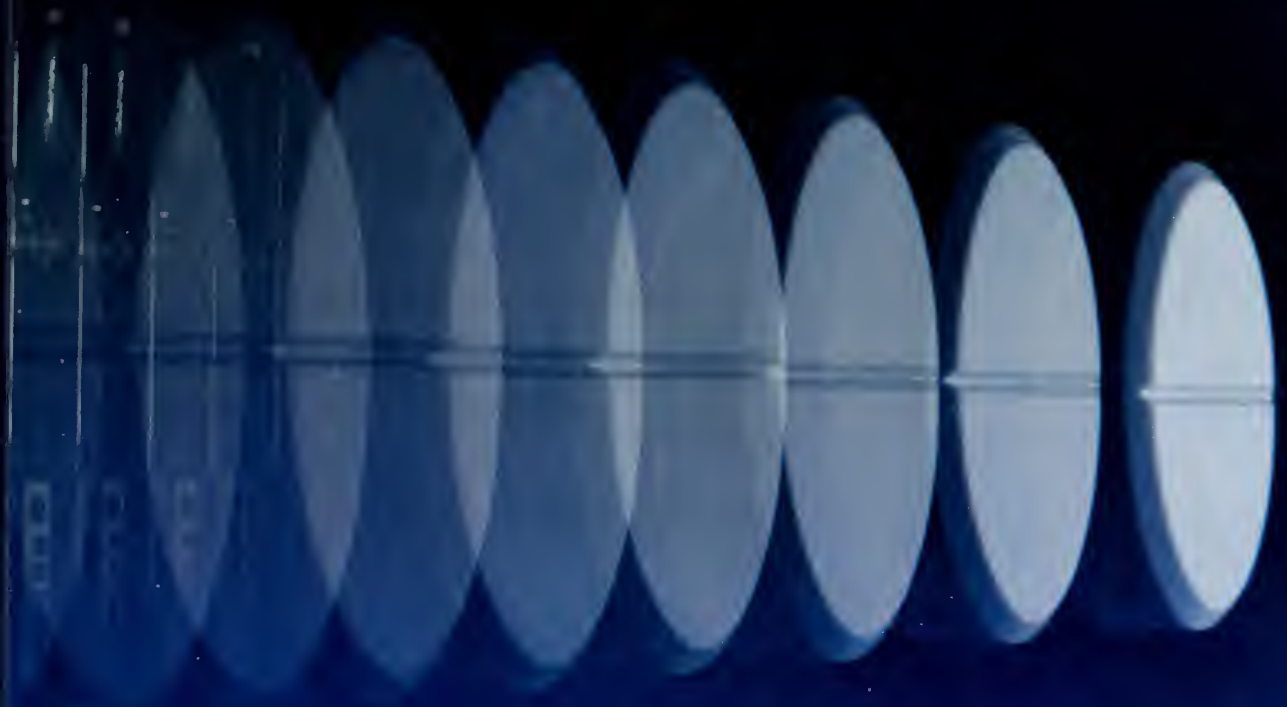
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Indications: Symptomatic relief and/or prevention of asthma and reversible bronchospasm associated with chronic bronchitis and emphysema.

Contraindications: THEO-DUR is contraindicated in individuals who have shown hypersensitivity to any of its components or xanthine derivatives.

Warnings: Excessive theophylline doses may be associated with toxicity; serum theophylline levels should be monitored to assure maximum benefit with minimum risk. Incidence of toxicity increases at serum levels greater than 20 mcg/ml. High blood levels of theophylline resulting from conventional doses are correlated with clinical manifestations of toxicity in: patients with lowered body plasma clearances, patients with liver dysfunction or chronic obstructive lung disease, and patients who are older than 55 years of age, particularly males. There are often no early signs of less serious theophylline toxicity such as nausea and restlessness, which may appear in up to 50% of patients prior to onset of convulsions. Ventricular arrhythmias or seizures may be the first signs of toxicity.

Many patients who have higher theophylline serum levels exhibit a tachycardia. Theophylline products may worsen pre-existing arrhythmias.

Usage in Pregnancy: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development, but neither have adverse effects on fetal development been established. This is, unfortunately, true for most anti-asthmatic medications. Therefore, use of theophylline in pregnant women should be balanced against the risk of uncontrolled asthma.

Precautions: THEO-DUR TABLETS SHOULD NOT BE CHEWED OR CRUSHED. Theophyllines should not be administered concurrently with other xanthine medications. It should be used with caution in patients with severe cardiac disease, severe hypoxemia, hypertension, hyperthyroidism, acute myocardial injury, cor pulmonale, congestive heart failure, liver disease and in the elderly, particularly males, and in neonates. Great caution should be used in giving theophylline to patients in congestive heart failure since these patients show markedly prolonged theophylline blood level curves. Use theophylline cautiously in patients with history of peptic ulcer. Theophylline may occasionally act as a local irritant to G.I. tract although gastrointestinal symptoms are more commonly central and associated with high serum concentrations above 20 mcg/ml.

Adverse Reactions: The most consistent adverse reactions are usually due to overdose and are:

Gastrointestinal: Nausea, vomiting, epigastric pain, hematemesis, diarrhea.

Central Nervous System: Headaches, irritability, restlessness, insomnia, reflex hyperexcitability, muscle twitching, clonic and tonic generalized convulsions.

Cardiovascular: Palpitation, tachycardia, extrasystoles, flushing, hypotension, circulatory failure, life threatening ventricular arrhythmias.

Respiratory: Tachypnea.

Renal: Albuminuria, increased excretion of renal tubular cells and red blood cells; potentiation of diuresis.

Others: Hyperglycemia and inappropriate ADH syndrome.

How Supplied: THEO-DUR 100 mg, 200 mg and 300 mg Sustained Action Tablets are available in bottles of 100, 1000, and 5000, and in unit dose packages of 100 (20 x 5's).

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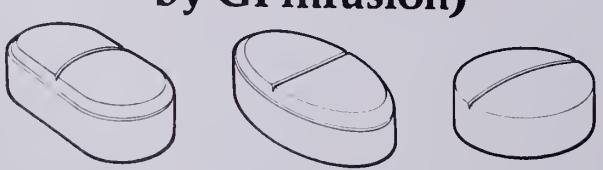
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INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below

CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).

WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect: rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. *Drug Dependence* Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. *Use in Pregnancy*. Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children*: Tenuate is not recommended for use in children under 12 years of age.

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

ADVERSE REACTIONS: *Cardiovascular*: Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System:* Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal*: Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic*: Urticaria, rash, ecchymosis, erythema, *Endocrine*: Impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System*: Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous* A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in midevening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg tablet daily, swallowed whole, in midmorning. Tenuate is not recommended for use in children under 12 years of age.

OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid resoiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

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References: 1. Citations available on request from Medical Research Department, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M.T., O'Dillon [Dillon], R.H., and Leyland, H.M. A comprehensive review of diethylpropion hydrochloride. In, Central Mechanisms of Anorectic Drugs, S. Garattini and R. Samanin, Ed., New York, Raven Press, 1978, pp. 391-404

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75 mg. controlled-release tablets



A useful short-term adjunct in an indicated weight loss program.

Overweight patients in certain diagnostic categories often require strict appetite control and a successful program of weight reduction may tend to diminish the incidence or severity of the complications in some patients. Diethylpropion hydrochloride has been reported useful in such patients and while it is not suggested that Tenuate itself in any way reduces the complications of overweight, it may have a useful place as a short-term adjunct in a prescribed dietary regimen. **Tenuate should not be administered to patients with severe hypertension; see additional Warnings and Precautions on the opposite page.**

In uncomplicated overweight.

Many patients, on the other hand, present with excess fat but no disease. While this condition is often termed uncomplicated obesity, complications of both a social and a psychologic nature may be distressingly real for the patients. In these cases, a short-term regimen of Tenuate can help reinforce your dietary counsel during the important early weeks of an indicated weight loss program.

Clinical effectiveness.

The anorectic effectiveness of diethylpropion hydrochloride is well documented. No less than 16 separate double-blind, placebo-controlled studies attest to its usefulness in daily practice.[1] And the unique chemistry of Tenuate provides "...anorectic potency with minimal overt central nervous system or cardiovascular stimulation."[2] Compared with the amphetamines, diethylpropion has minimal potential for abuse.

Tenuate—it makes sense. And it's responsible medicine.

*Studies have shown that obesity is associated with an increased incidence of hypertension, symptomatic heart disease, adult-onset diabetes, and other diseases.

Merrell

For prescribing information see opposite page.

In G.I. therapy



Adjunctive Librax®

Each capsule contains
5 mg chlordiazepoxide HCl
and 2.5 mg clidinium Br

antianxiety/antisecretory/antispasmodic

for adjunctive therapy of duodenal ulcer* and irritable bowel syndrome*

Librax®

Please consult complete prescribing information, a summary of which follows:

* **Indications:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:
"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis
Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma, prostatic hypertrophy, benign bladder neck obstruction, hypersensitivity to chlordiazepoxide HCl and/or clidinium Bromide

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl/Roche) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

***Usage in Pregnancy*: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets

ROCHE®

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WHEN ANXIETY AND TENSION MAGNIFY PAIN IN MUSCULOSKELETAL DISEASE*

A non-narcotic one-two punch against pain, with concurrent relief of anxiety/tension

EQUAGESIC® C IV

meprobamate and ethoheptazine citrate with aspirin) Wyeth

UAGESIC—Abbreviated Summary

NDICATIONS: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified he indications as follows.
"Possibly" effective for the treatment of pain accompanied by tension and/or anxiety in patients with musculoskeletal disease or tension headache.
Final classification of the less-than-effective indications requires further investigation.
The effectiveness of Equagesic in long-term use, i e more than four months, has not been assessed by systematic clinical studies The physician should periodically reassess usefulness of the drug for the individual patient.

NTRAINDICATIONS: Equagesic should not be given to iduals with a history of sensitivity or severe intolerance spirin, meprobamate, or ethoheptazine citrate.

RNINGS: Careful supervision of dose and amounts prescribed for patients is advised, especially with those patients known propensity for taking excessive quantities of drugs assive and prolonged use in susceptible persons, e.g., holics, former addicts, and other severe psychoneurotics has been reported to result in dependence on or habituation to the drug. Where excessive dosage has continued weeks or months, dosage should be reduced gradually r than abruptly stopped, since withdrawal of a "crutch" precipitate withdrawal reaction of greater proportions that for which the drug was originally prescribed Abrupt ntinuance of doses in excess of the recommended dose esulted in some cases in the occurrence of epileptiform res
ial care should be taken to warn patients taking meprote that tolerance to alcohol may be lowered with reent slowing of reaction time and impairment of judgement oordination.
GE IN PREGNANCY AND LACTATION: An increased risk of congenital malformations associated with se of minor tranquilizers (meprobamate, chlordiazepoxide, and diazepam) during the first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a women of child-bearing potential may be pregnant at the time of institution of therapy should be considered. Patients should be advised that if they become pregnant during therapy or intend to become pregnant they should communicate with their physicians about the desirability of discontinuing the drug.
Meprobamate passes the placental barrier. It is present both in umbilical-cord blood at or near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breast-feeding patients, the drug's higher concentrations in breast milk as compared to maternal plasma levels should be considered.
Preparations containing aspirin should be kept out of the reach of children Equagesic is not recommended for patients 12 years of age and under

PRECAUTIONS: Should drowsiness, ataxia, or visual disturbance occur, the dose should be reduced If symptoms continue, patients should not operate a motor vehicle or any dangerous machinery
Suicidal attempts with meprobamate have resulted in coma, shock, vasomotor and respiratory collapse, and anuria Very few suicidal attempts were fatal, although some patients ingested very large amounts of the drug (20 to 40 gm) These doses are much greater than recommended. The drug should be given cautiously and in small amounts, to patients who have suicidal tendencies In cases where excessive doses have been taken, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels Hyperventilation has been reported occasionally Any drug remaining in the stomach should be removed and symptomatic treatment given. Should respiration become very shallow and slow, CNS stimulants, e g , caffeine, Metrazol, or amphetamine, may be cautiously administered If severe hypotension develops, pressor amines should be used parenterally to restore blood pressure to normal levels.

ADVERSE REACTIONS: A small percentage of patients may experience nausea with or without vomiting and epigastric distress Dizziness occurs rarely when meprobamate and ethoheptazine citrate with aspirin is administered in recommended dosage. The meprobamate may cause drowsiness but, as a rule, this disappears as therapy is continued Should drowsiness persist and be associated with ataxia, this symptom can usually be controlled by decreasing the dose, but occasionally it may be desirable to administer central stimulants such as amphetamine or mephentermine sulfate concomitantly to control drowsiness
A clearly related side effect to the administration of meprobamate is the rare occurrence of allergic or idiosyncratic reactions This response develops, as a rule, in patients who have had only 1-4 doses of meprobamate and have not had a previous contact with the drug Previous history of allergy may or may not be related to the incidence of reactions
Mild reactions are characterized by an itchy urticarial or erythematous, maculopapular rash which may be generalized or confined to the groin Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, penpheral edema, and fever have also been reported
More severe cases, observed only very rarely, may also have other allergic responses, including fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case), and hyperthermia Treatment should be symptomatic such as administration of epinephrine, antihistamine, and possibly hydrocortisone Meprobamate should be stopped, and reinstitution of therapy should not be attempted
Rare cases have been reported where patients receiving meprobamate suffered from aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia In nearly every instance reported, other toxic agents known to have caused these conditions have been associated with meprobamate A few cases of leukopenia during continuous administration of meprobamate are reported, most of these returned to normal without discontinuation of the drug
Impairment of accommodation and visual acuity has been reported rarely.

OVERDOSE: Two instances of accidental or intentional significant overdosage with ethoheptazine citrate combined with aspirin have been reported These were accompanied by symptoms of CNS depression, including drowsiness and light-headedness, with uneventful recovery However, on the basis of pharmacological data, it may be anticipated that CNS stimulation could occur Other anticipated symptoms would include nausea and vomiting Appropriate therapy of signs and symptoms as they appear is the only recommendation possible at this time Overdosage with ethoheptazine combined with aspirin would probably produce the usual symptoms and signs of salicylate intoxication Observation and treatment should include induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs usually requires whole-blood transfusions

DESCRIPTION: Each Equagesic tablet contains 150 mg meprobamate 75 mg ethoheptazine citrate and 250 mg aspirin

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*This drug has been evaluated as possibly effective for this indication

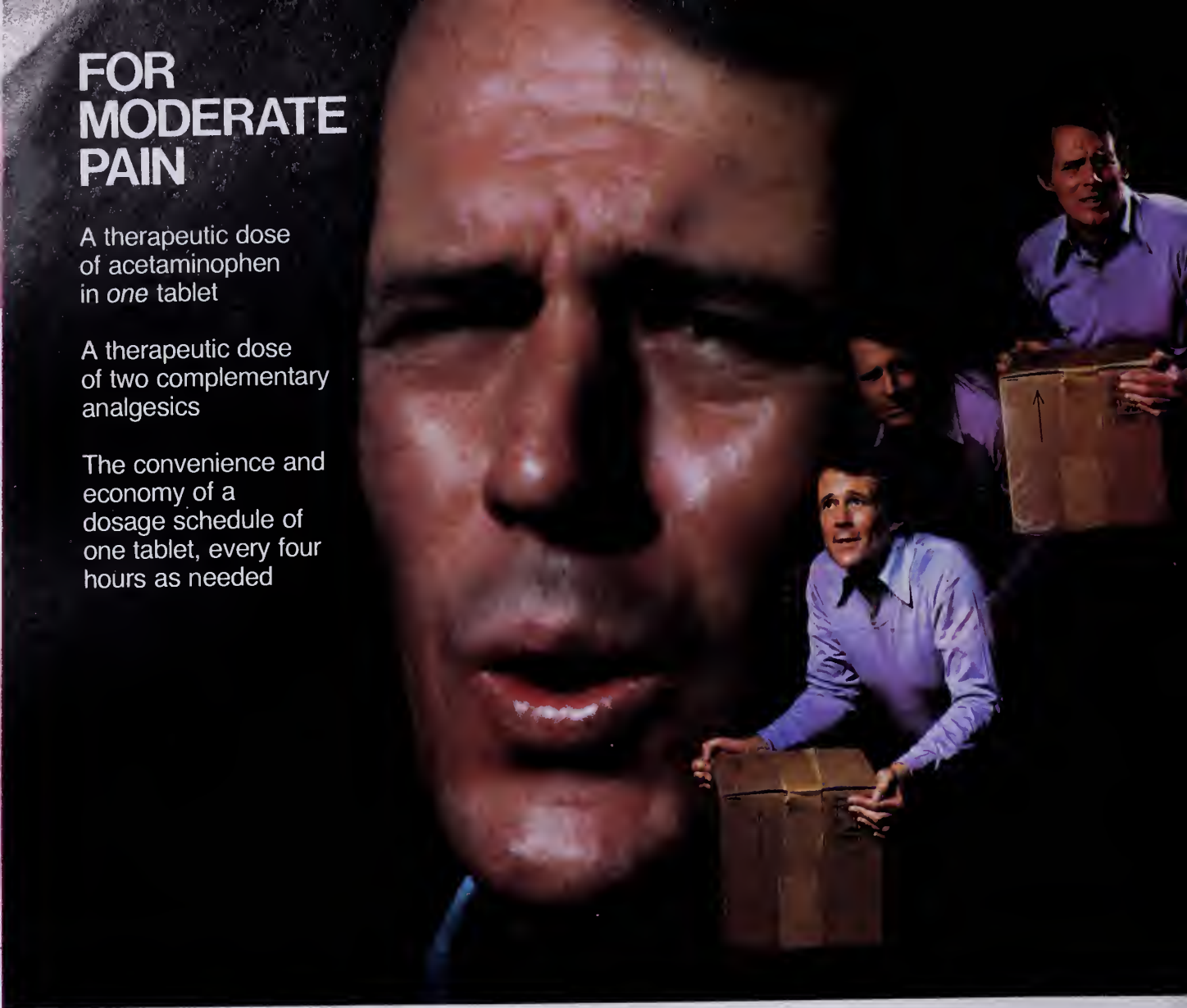
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FOR MODERATE PAIN

A therapeutic dose of acetaminophen in *one* tablet

A therapeutic dose of two complementary analgesics

The convenience and economy of a dosage schedule of one tablet, every four hours as needed



WHY NOT WYGESIC® ℠

(65 mg propoxyphene HCl and 650 mg acetaminophen) Wyeth

WYGESIC—Abbreviated Summary

INDICATION: For the relief of mild-to-moderate pain.

CONTRAINDICATION: Hypersensitivity to propoxyphene or to acetaminophen.

WARNINGS: CNS ADDITIVE EFFECTS AND OVERDOSAGE. Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, or other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. Toxic effects and fatalities have occurred following overdoses of propoxyphene alone or in combination with other CNS depressants. Most of these patients had histories of emotional disturbances or suicidal ideation or attempts, as well as misuse of tranquilizers, alcohol, or other CNS-active drugs. Caution should be exercised in prescribing large amounts of propoxyphene for such patients (see **Management of Overdosage**).

DRUG DEPENDENCE: Propoxyphene can produce drug dependence characterized by psychic dependence and less frequently, physical dependence and tolerance. It will only partially suppress the withdrawal syndrome in individuals physically dependent on morphine or other narcotics. The abuse liability of propoxyphene is qualitatively similar to codeine's although quantitatively less, and propoxyphene should be prescribed with the same degree of caution appropriate to the use of codeine.

USAGE IN AMBULATORY PATIENTS: Propoxyphene may impair the mental and/or physical abilities required for potentially hazardous tasks, e.g. driving a car or operating machinery. Patients should be cautioned accordingly.

USAGE IN PREGNANCY: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. INSTANCES OF WITHDRAWAL SYMPTOMS IN THE NEONATE HAVE BEEN REPORTED FOLLOWING USAGE DURING PREGNANCY. Therefore, propoxyphene should not be used in pregnant women unless, in the judgement of the physician, the potential benefits outweigh the possible hazards.

USAGE IN CHILDREN: Propoxyphene is not recommended for children because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric group.

PRECAUTIONS: Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine. The CNS depressant effect of propoxyphene may be additive with other CNS depressants, including alcohol.

ADVERSE REACTIONS: The most frequent adverse reactions are dizziness, sedation, nausea, and vomiting. These seem more prominent in ambulatory than in nonambulatory patients; some of these reactions may be alleviated if the patient lies down.

Other adverse reactions include constipation, abdominal pain, skin rashes, light-headedness, headache, weakness, euphoria, dysphoria, and minor visual disturbances. The chronic ingestion of propoxyphene in doses over 800 mg per day has caused toxic psychoses and convulsions. Cases of liver dysfunction have been reported.

DRUG INTERACTIONS: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, and other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. (see **Warnings**)

Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine.

MANAGEMENT OF OVERDOSAGE: SYMPTOMS

The manifestations of serious overdosage with propoxyphene are similar to those of narcotic overdosage and include respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, pupillary constriction, and circulatory collapse. In addition to these characteristics, which are reversed by narcotic antagonists such as naloxone, there may be other effects. Overdoses of propoxyphene can cause delay of cardiac conduction as well as focal or generalized convulsions, a prominent feature in most cases of severe poisoning. Cardiac arrhythmias and pulmonary edema have occasionally been reported, and apnea, cardiac arrest, and death have occurred.

Symptoms of massive overdosage with acetaminophen may include nausea, vomiting, anorexia, and abdominal pain, beginning shortly after ingestion and lasting for 12 to 24 hours. However, early recognition may be difficult since early symptoms may be mild and nonspecific. Evidence of liver damage is usually delayed. After the initial symptoms, the patient may feel less ill; however, laboratory determinations are likely to show a rapid rise in liver enzymes and bilirubin. In case of serious hepatotoxicity, jaundice, coagulation defects, hypoglycemia, encephalopathy, coma, and death may follow. Renal failure due to tubular necrosis, and myocardiopathy, have also been reported.

Ingestion of 10 grams or more of acetaminophen may produce hepatotoxicity. A 13-gram dose has reportedly been fatal.

TREATMENT: Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation. The narcotic antagonists, naloxone, nalorphine, and levallorphen, are specific antidotes against the respiratory depression produced by propoxyphene. An appropriate dose of one of these antagonists should be administered, preferably IV, simultaneously with efforts at respiratory resuscitation and the antagonist should be repeated as necessary until the patient's condition remains satisfactory. In addition to a narcotic antagonist, the patient may require careful titration with an anticonvulsant to control seizures. Analeptic drugs (e.g. caffeine or amphetamine) should not be used because of their tendency to precipitate convulsions.

Oxygen, IV fluids, vasopressors and other supportive measures should be used as indicated. Gastric lavage may be helpful. Activated charcoal can absorb a significant amount of ingested propoxyphene. Dialysis is of little value in poisoning by propoxyphene alone. Acetaminophen is rapidly absorbed and efforts to remove the drug from the body should not be delayed. Copious gastric lavage and/or induction of emesis may be indicated. Activated charcoal is probably ineffective unless administered almost immediately after acetaminophen ingestion. Neither forced diuresis nor hemodialysis appears to be effective in removing acetaminophen. Since acetaminophen in overdose may have an antidiuretic effect and may produce renal damage, administration of fluids should be carefully monitored to avoid overload. It has been reported that mercaptamine (cysteamine) or other thiol compounds may protect against liver damage if given soon after overdosage (8-10 hours). N-acetylcysteine is under investigation as a less toxic alternative to mercaptamine, which may cause anorexia, nausea, vomiting, and drowsiness. Appropriate literature should be consulted for further information. (JAMA 237:2406-2407, 1977)

Clinical and laboratory evidence of hepatotoxicity may be delayed up to one week. Acetaminophen plasma levels and half-life may be useful in assessing the likelihood of hepatotoxicity. Serial hepatic enzyme determinations are also recommended.

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Special Issue
Family Practice

Guest Editor
Cranford O. Plyler Jr., M.D.



Dr. Plyler

Family Practice—1980

The decade of the 1970's nurtured family practice, the twentieth American medical specialty. Retrospection allows us to perceive many developments of which we are proud; with deeper introspection, humility must prevail, for there are many accomplishments yet to be achieved if family practice is to maintain vigor and claim its proper place among valid academic disciplines.

Seven thousand residents are in training in 384 approved family practice residency programs. Family practice captures the interest of large numbers of medical students. The students who enter family practice residencies come from the top percentiles of medical school classes. The fill-rate of family practice residencies is high, second only by a small fraction to internal medicine.

Family physicians risk losing specialty status if we do not fortify our specialty through arduous preparation for the practice of our discipline, through tenacious adherence to continuing education and recertification of our specialists, and through continuing, comprehensive delivery of health care to our patients.

We draw strength from 22 other specialties in American medicine. Much as we need inherent strengths as clinicians, we need on an equal status sustaining guidance and augmentation of our clinical abilities through appropriate consultation and referral. We cannot abrogate, without reducing our clinical effectiveness, our continuing advocacy role with the patient and the family even when the most esoteric of medical specialists is required for proper patient management.

The authors of these articles reflect the many-faceted approaches a family physician must take in providing broad-based health care. From preventive medicine to hospice care, from medical education to

Dr. Plyler is Director of the Family Practice Residency Program, St. Vincent's Medical Center, Jacksonville; Chairman of the Department of Family Practice, Jacksonville Health Education Program; Associate Professor, University of Florida College of Medicine; and former President of the North Carolina Academy of Family Physicians.

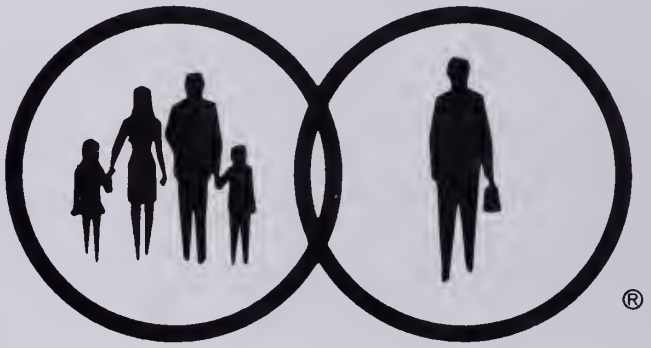
plastic surgery, the family physician's role is one requiring vast resources of understanding and the ability to play many parts in a scenario featuring life and death.

The family physician's greatest responsibility must be directed to academic excellence in the discipline of family practice and to exemplary delivery of health care to those who seek his ministry.

Articles throughout this special Family Practice Issue of *The Journal of the Florida Medical Association* attest to the academic development of the specialty of family practice. Other articles are illustrative of the family physician's appropriate use of physicians in other specialties and of allied medical professionals. Journalistic contributions from practicing family physicians demonstrate the return of members of this specialty to medical literature. Family physician educators in Florida add to the growing store of medical knowledge germane to the 11 year old specialty of family practice. Nationally prominent physicians share their knowledge and support of family practice in Florida through the pages of this journal.

The physicians of Florida hail the 421 years of medical practice in Florida since the landing of the first surgeons and medico-friars on the shores of this penisula in 1559. We salute our colleagues in all specialties who have established excellence in medical education and health care, and we pledge, with God's help, to alleviate suffering and to enhance the quality of life for the people of Florida.

You who wrote this journal served well our profession. To you who have sustained me in the complilation of this journal is tendered an extra measure of gratitude.



The Family Practice Symbol

The above symbol of family practice was devised by the Public Relations Committee of the American Academy of Family Physicians and was registered officially March 26, 1974 by the U.S. Patent Office. The symbol serves as an instantly-recognizable identification of the specialty of family practice for use by members of the American Academy of Family Physicians on stationery, office buildings and in other ways conducive to the public's association of the symbol with the family physician and excellence in medical care.

Widespread appropriate use is encouraged, with control of its use in the hands of the executive director of AAFP. Many family practice residency programs display the logo as an identifying sign of family practice training centers.



President's Page

Common Goals

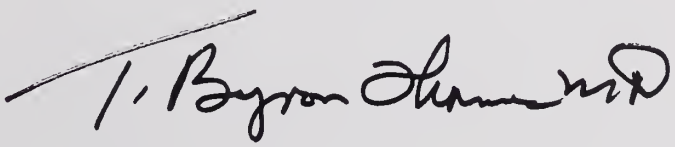
It is with distinct pleasure that I write this President's Page for this special issue of *The Journal of the Florida Medical Association*. I have the privilege of practicing family medicine as my professional occupation of choice. I have had the privilege of serving as an officer in both the Florida Academy of Family Physicians and the Florida Medical Association. I hope that I can express the feelings of both groups.

The last few years have seen a renaissance of family medicine. After a number of years in which many medical schools showed little interest in family practice teaching and post-graduate education, a new spirit of importance to the production and continuing education of physicians who wish to practice family medicine has evolved. The hope of all physicians, of whatever specialty, is that this trend will enable medicine to meet the needs and demands of patients and assist all of us in organized medicine in continuing the private practice of high quality health care.

I am proud that in Florida family physicians and other specialists have worked together cordially in the Florida Medical Association and in legislative programs for mutual benefit. Patients need family physicians and patients need specialists. We in medicine need each other. When we can agree on common goals which are for the ultimate benefit of our patients, we have been, and can continue to be, effective in educating patients and legislators about programs which serve them and the practice of medicine in the best interest of all concerned.

Many who would change the climate in which we practice our profession rejoice in the opportunity to divide us over issues such as dual fee schedules, national health insurance, PSRO and HMO's. When we can disregard personal gain and work toward principles which are best for our patients we can successfully protect our patients and our interests since they will coincide.

I have seen the American Academy of Family Physicians consistently work with and within the American Medical Association on solutions to national problems. Even when differences have arisen, the two groups have worked together in a democratic spirit to present a middle ground for unified support. This coalition has been beneficial to both organizations and to medical care for the American people. As we take pride in this family practice issue of *The Journal of the Florida Medical Association*, we join with our specialist colleagues in recognition of all the outstanding efforts made by organized medicine in Florida for the benefit of the health care needs of all Florida citizens.





Facets of Family Practice

John S. Derryberry, M.D.

I appreciate the opportunity to contribute to this special issue of *The Journal of the Florida Medical Association* which is devoted to family practice. In my opinion, the Florida Medical Association is very innovative in offering specialty groups the opportunity to participate, editorially, in the production of issues of its journal. Certainly, family physicians are in a position to prepare sound scientific material for publication. Extensive research gleaned from hitherto untapped sources in the fertile ground of family practice is currently being conducted by both practicing and teaching family physicians. This type of research should produce good scientific and socio-economic topics that will merit publication in the medical literature. We should all strive to publicize our work when the product is innovative, appropriate, and well produced.

The Florida Academy of Family Physicians has been a strong leader in the family practice movement. This Academy has won many membership honors for the diligent efforts of its staff in enlisting new active members, residents, and students. These efforts are now beginning to pay off in real benefits. Since last year, 99 percent of our resident members, on a national basis, who were eligible for conversion to active academy membership, converted to this status almost immediately after graduation. Medical student interest also continues to mount. The number of student affiliate members stands at more than 8,000, reflecting a 50 percent increase in three years.

A message I wish to convey to our other specialist colleagues is to try to dispel any idea that we in family practice want to compete with them unfairly to displace them. Nothing could be further from our minds. We simply want to practice family medicine within the boundaries of our training and competence. Our true motive is to complement our peers in other specialties, utilizing them for good patient care when their special talents and training are needed. It is inappropriate and inefficient for highly trained subspecialists to be doing primary care. Most of the time they do not enjoy it, and frequently they do less than an adequate job of providing comprehensive continuing care.

The need for family physicians in rural areas is being met. Over 50 percent of the 1979 family practice residency graduates now practice in cities with populations of 30,000 or less. A crying need for physicians remains in urban, suburban, and inner-city areas. The American Academy of Family Physicians is addressing these needs in a forceful manner. The academy's newly created Minority Health Affairs Committee will study the problem of providing physicians to inner-city areas. Hopefully, family physicians can bring order to the chaos that exists there. A more cost-efficient form of practice needs to be developed to reduce the over-utilization of emergency rooms, currently the only source of medical care for many people.

Another often overlooked segment of society is the aging population. The Academy has created an Ad Hoc Task Force on Aging to address the special needs of the elderly and to help cast the role family physicians must play in meeting these needs.

Finally, a mandate that all physicians should heed during the decade of the 1980's is the education of our patients to assume more responsibility for their own health care by cultivating healthier lifestyles. Florida has led the nation in mounting a *tour de force* of educating patients to the harmful effects of excessive tobacco and alcohol consumption and to the need for greater highway safety. It will be many years before these educational efforts take tangible form. But if the efforts of the medical profession persist, and they must, the tangible results will be a healthier American nation.

Dr. Derryberry is President of the American Academy of Family Physicians.

Florida Academy of Family Physicians

Cooperation

Kenneth C. Kiehl, M.D.

On behalf of the 1,123 practicing family/general practitioner members of the Florida Academy of Family Physicians, it gives me great pleasure to write for this special issue of *The Journal of the Florida Medical Association*, sponsored by the Florida Academy of Family Physicians. It is the culmination of one and one-half years of work by our guest editor, C. O. Plyler Jr., M.D., of Jacksonville.

Medicine has come a long way in the 32 years since our Academy was formed. Eleven years ago a new breed of general practitioner arrived and took the name of family physician. These physicians have come a long way.

Some of our colleagues are not aware of the breadth of education accorded today's family physician. They may not know that we are specifically taught to seek the guidance and expertise of other specialists on patients' problems for which we cannot provide care. To you, our colleagues in other specialties, we are especially grateful for your availability when we need your help.

We bring to you in this *Journal* papers that give you insight and understanding of our specialty. Our efforts are designed to emphasize our special attributes and to promote better understanding among physicians in Florida. We hope you will find this *Journal* interesting, enjoyable, and useful.

Dr. Kiehl is President of the Florida Academy of Family Physicians, and practices in Sarasota.

Historical Perspectives in Family Practice

Marshall D. Brainard, B.S. and Cranford O. Plyler Jr., M.D.

The concept of accessible, comprehensive, and continuing care for all members of the family is axiomatic to family practice today. These were not words in the vernacular of practitioners in Florida prior to 1900, but Florida's early physicians were charged by practical reality with the care of all the people living in a state which was remote from the medical centers of that day. Some physicians of early Florida were rogues and charlatans. Others were exceptional individuals whose skills and concepts were ahead of their times. Most physicians were good men doing their best with limited knowledge and tools, but all reflected the inadequate level of medical education and professional performance characteristic of the pre-Flexnerian era.

The Flexner Report, which thrust medical education out of its apprenticeship system in vogue during the seventeenth and eighteenth centuries, heralded the advent of the greatest system of medical education in the world. Dr. Flexner had recognized physicians' unfitness for practice on graduation from the medical schools of the early 1900's and determined that the postgraduate school would do what the medical school had failed to accomplish. Nineteen years after Dr. Flexner described postgraduate medical education as developed in the United States to be "conpensatory adjustment," the first internship in Florida was established at Jackson Memorial Hospital in Miami.

Decline in General Practice

The trend toward medical specialization began with self-development in areas of special interest by physicians prior to the existence of formal specialty training programs. Military medical duty in World War I moved others into narrower fields of practice. The trend accelerated with the diversified needs of military medicine in World War II and the spectacular growth in the science of medicine since 1945. Governmental interest in medical research and the availability of research funding affected the structure of medical schools. The Hill-Burton hospital boom supported specialty orientation of medical staffs; and intra-professional attitudes, which downgraded general practice, influenced career choices of medical students. An American philosophy holding specialization as high attainment was accepted by medicine and minimized the integrity of the patient as a whole human being.

One hundred twelve thousand physicians classified themselves as general practitioners in the American Medical Association's annual directory of 1931. This number had declined to 66,000 in 1965 and to 54,332 by 1976.

Birth of the General Practice Academy

Strong advocates of general practice in a smoke-filled room in Atlantic City in 1947, alarmed at their dwindling voices in medicine, sired a new concept in medicine by organizing the American Academy of General Practice. Thus began the 22 year struggle toward board certification in the specialty of Family Practice and recognition of the family physician as one who bears specialty status and who has an academic base from which specific and unique skills have been developed.

Floridians Richard Mills and Norris Beasley, both of Fort Lauderdale, took part in the conception activities in Atlantic City and in the first AAGP national convention in Cincinnati in 1948. They returned to Florida to spread the story of the new medical organization. The resulting enthusiasm wedded the General Practice Section of the Florida Medical Association to the newly formed Florida Academy of General Practice in Daytona Beach on May 24, 1948. Dr. Mills was selected charter president and Dr. Beasley became charter secretary.

Florida Academy of General Practice

Formal dissolution of the General Practice Section of the Florida Medical Association in 1949 and election of Dr. Walter Murphree, of Gainesville, began a long line of capable and enthusiastic presidents of the Florida Academy of General Practice.

By 1951 two hundred members of the Academy

The Authors

MARSHALL D. BRAINARD, B.S.

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Historical Highlights in Time Perspective

1559 Spanish DeLuna exposition in Florida had "surgeons" and medico-friars.

1597 First record of a hospital in Spanish Florida, in St. Augustine.

1698 Arriola Exposition boasted three surgeons.

1775 The British built a hospital in Pensacola.

1822 Key West was occupied by the United States, withered to a ghost town by 1826 due to yellow fever, but recovered to become Florida's largest community by 1850, with 3,000 population.

1851 Duval County Medical Society (Jacksonville) founded.

1874 Florida Medical Association founded.

1889 Florida State Board of Health created in response to yellow fever epidemics.

1892 Dr. Eleanor Galt Simmons was first female physician in Dade County, when Coral Gables had less than 500 population.

1899 First electric plant and telephone in Miami. The first automobile arrived two years later.

1910 Flexner study began revolution in medical training in the U.S.

1917 American Board of Ophthalmology founded.

1929 Jackson Memorial Hospital, Miami, accredited for internship by AMA.

1930 Blue Cross first attempted group health insurance plans.

1933 American Board of Pediatrics founded.

1935 Social Security extended old age insurance.

1936 American Board of Internal Medicine founded.

1946 Hill Burton legislation triggered rapid hospital growth.

1947 American Academy of General Practice founded in Altantic City, New Jersey.

1948 Florida Academy of General Practice founded.

1958 J. Hillis Miller Health Center, University of Florida College of Medicine, Gainesville, completed.

1965 Social Security initiated Medicare and Medicaid benefits.

1969 American Board of Family Practice approved.

1971 American Academy of General Practice became the American Academy of Family Physicians and state chapters followed the pattern.

1972 Departments of family practice initiated at University of Florida and University of Miami.

1975 Department of family practice started at University of South Florida.

received the first issue of the mimeographed *Florida Newsletter*, edited by Dr. L. Paul Foster, of Orlando. A slick, printed *Florida Newsletter* replaced its modest predecessor in January 1953 and was sent to all GP's in Florida. The publication's name was changed in July 1954 to the *Journal of the Florida Academy of General Practice* (predecessor of *Florida Family Physician*) and in 1955 its mailing was expanded, as the voice of general practice, to all members of the Florida Medical Association.

As membership increased so did the administrative burdens on elected officers, and in 1956, during the presidency of Dr. Leo M. Wachtel, of Jacksonville, Mr. Marshall D. Brainard was selected as executive secretary of the Academy and the office of the Academy in Jacksonville was established by contract.

The Academy easily survived its developmental years and in the 1950's and 1960's grew in acceptance and influence as a specialty organization in the Florida medical community. Gradually more general practitioners were elected to leadership positions in county medical societies and the Florida Medical Association. Florida Academy members enjoyed appointive and elective offices in the American Academy of General Practice, including three vice presidents of AAFP, Dr. Walter W. Sackett Jr., of Miami, Dr. Leo M. Wachtel, of Jacksonville, and Dr. Norman F. Coulter, of Orlando.

Continuing concern over lack of academically creditable educational programs for the generalist in Florida was expressed during annual visits by representatives of the Academy with the deans of the medical school at Gainesville from the earliest days of the school. Deans George Harrell and Emanuel Suter were pleasant and generally supportive, but solutions were not forthcoming. Death, retirement and specialty training continued to deplete the limited ranks of general practitioners and meager replenishment came from practitioners moving into Florida.

Arena for Development of Family Practice

Sensing the trend of decline in general practice and its resultant dangers, the Southern Medical Association founded the first Section of General Practice early in the 1940's, to be followed soon by the AMA and Florida Medical Association.

While some movements were made within the American Medical Association (AMA) as early as 1941 seeking identification for general practice, nothing of consequence surfaced until the AMA Committee on Medical Practice in 1956 reported on the directive to "utilize all possible means to stimulate the formation of a department of general practice in each medical school," and to state that much needed to be done to properly define general practice and "to determine more ade-

Presidents of the Florida Academy of General Practice	
1948	Richard Mills, M.D., Ft. Lauderdale (Deceased)
1949	Walter E. Murphree, M.D., Gainesville
1950	T. Douglas Sandberg, M.D., Coral Gables
1951	Elmer Leitner, M.D., Jacksonville
1952	Edward F. Shaver, M.D., Tampa (Deceased)
1953	R. R. Killinger, M.D., Jacksonville (Deceased)
1954	Leonard Weil, M.D., Miami Beach
1955	Frank T. Linz, M.D., Tampa
1956	Leo M. Wachtel, M.D., Jacksonville
1957	Henry L. Harrell Sr., M.D., Ocala
1958	Charles R. Sias, M.D., Orlando
1959	Walter J. Glenn, M.D., Ft. Lauderdale
1960	Elmer Campbell Sr., M.D., St. Petersburg (Deceased) W. E. Manry Jr., M.D., Lake Wales
1961	James T. Cook, M.D., Marianna
1962	Franklin J. Evans, M.D., Miami
1963	A. Mackenzie Manson, M.D., Jacksonville
1964	George Edwards, M.D., Orlando
1965	Walter W. Sackett Jr., M.D., Miami
1966	Louis C. Murray, M.D., Orlando
1967	Frederick C. Andrews, M.D., Mount Dora
1968	Edward G. Haskell Jr., M.D., Tallahassee
1969	Joseph C. Von Thron, M.D., Cocoa Beach
1970	Leon S. Eisenman, M.D., Miami Beach
1971	Edward W. Stoner, M.D., Oviedo

quately the avenues of approach to the best indoctrination today for the individual who plans to enter the field of general practice."

A joint committee, with representation from the AMA, the Council on Medical Education, the American Association of Medical Colleges, and the American Academy of General Practice, was established by the AMA in 1957 to address itself to the directives in the report of the Committee on Medical Practice. In June 1959 the final report of that Committee on Preparation for General Practice was approved by the AMA and referred to the Council on Medical Education for implementation.

In the early 1960's, four major studies sought the answer to the question, "What's wrong with the delivery of health care in America?":

1) **The National Commission on Community Health Services**, under the chairmanship of Marion B. Folsom, former Secretary of Health, Education and Welfare.
2) **The Citizen's Commission on Graduate Medical Education**, headed by Dr. John Millis, President of Western Reserve University.
3) **The Ad Hoc Committee on Education for Family Practice**, established by the Council on Medical Education of the AMA, under the chairmanship of Dr. William R. Willard, then Dean of the University of Kentucky Medical School.
4) **The Conferences of the Family Health Foundation of America**, chaired by Dr. Ward Darley, previously the President of the University of Colorado and Executive Director of the Association of American Medical Colleges.

These four studies, independent of each other, arrived at a single conclusion: "Every individual should have a personal physician who is the central point for integration and continuity of all medical and medically related services to his patient."

Battles raged about the content of general practice, particularly regarding obstetrics and surgery. There was marked disagreement among general practitioners about certification and the compatibility of the concept of specialization with that of general practice. But in 1965 the Congress of Delegates of the American Academy of General Practice directed Academy officers to proceed with an application for a certifying board. A committee comprised of Academy and AMA Section of General Practice representatives got to work on determining the exact mechanism for application. Named the Committee on Requirements for Certification, it quickly became known by the acronym "CORC."

In February 1966 the Liaison Committee for Specialty Boards considered a preliminary application from the Academy and Section, but another three years were consumed in additional application, creation of the "Core Content of Family Practice," and approval of "The Essentials — Special Requirements for Residency Training in Family Practice." The final application was considered by the Liaison Committee for Specialty Boards and by the Standards Committee before it was approved by the full 49-member American Board of Medical Specialties and the full AMA Council on Medical Education. The American Board of Family Practice was born on February 8, 1969.

There would be no "grandfathering." All who would be diplomates would have to pass the certification examination. Certification would be for six years, with compulsory periodic recertification. The initial examination of the American Board of Family Practice was given on

February 28-March 1, 1970, and a number of Florida physicians became ABFP Charter Diplomates.

Education and Training for Family Practice in Florida

Building on the base of the "Core Content of Family Practice" and "The Essentials — Special Requirements for Residency Training in Family Practice," departments of family medicine and family practice residencies appeared in Florida early in the 1970's.

Pioneering efforts from 1965 by Dr. Lynn P. Carmichael resulted in AMA approval of Florida's first family practice residency program at the University of Miami School of Medicine in 1971, followed closely by the residency at Halifax Hospital Medical Center in Daytona Beach. The program at St. Vincent's Medical Center, Jacksonville, received its approval in 1972. Nineteen seventy-three saw the first classes of residents in family practice in Orlando, St. Petersburg, and Tallahassee. The Pensacola residency received it approval in 1978. Meanwhile these community hospital-based programs were joined by two United States Navy programs (Jacksonville and Pensacola) and one Air Force family practice residency (Eglin Air Force Base) to bring approved family practice residencies in Florida to a total of 11.

Family medicine achieved full departmental status at the University of Miami School of Medicine in 1972. That same year the Department of Community Health and Family Medicine was established in the College of Medicine, University of Florida. Three years later the Department of Family Medicine was initiated at the University of South Florida in Tampa.

Family practice educators, at the suggestion of Dr. Carmichael, organized the Florida Council on Graduate Education for Family Practice in July, 1972, with Dr. L.E. Masters as its first chairman. The Council's purpose: To provide a forum by which departmental chairmen, residency directors, and others involved in family practice teaching could work together on common problems and goals.

State of Florida Support for Family Practice Training

An Institute on Florida Government, sponsored by the Academy with the cooperation of the Florida Medical Association and co-sponsorship of Smith Kline and French Laboratories, brought 21 legislators, department and staff heads from Florida government together with 50 leaders of several medical specialties in Florida at Lake Buena Vista, Florida, on November 2-4, 1973. The weekend of unstructured small group discussions disclosed strong interest among legislators in the development of more family physicians for the state, led by Rep. William Conway, Chairman of the House Education Committee, and triggered a major drive by the Academy for State of Florida funding assistance to family practice residency programs.

Dr. Edward G. Haskell Jr., Chairman of the Academy's Committee on Legislation, and many other Academy members worked with key legislators throughout years 1974 and 1975, culminating in a formal conference of legislators and physicians in Miami in January 1976. As a result, substantial categorical funding for family practice graduate training, as a continuing commitment of Florida government, was signed into law by Governor Rubin Askew on June 8, 1976.

Today

The name of the Florida Academy of General Practice was changed to the Florida Academy of Family Physicians on Sunday, October 3, 1971. A new headquarters office was established in Jacksonville in January 1973 with Mr. Marshall D. Brainard as its full time staff director. Today the staff of four includes Mr. Brainard, as Executive Vice President, and Mrs. Martha Jane Moores, as Executive Secretary.

Three medical students, three family practice residents and the three chairmen of the medical school departments of family practice have been added to the Board of Directors of the Florida Academy.

Family Practice Weekends, multi-purpose meetings of the FAFP Board of Directors and its committees plus 12 hours of approved continuing medical education sessions, are held annually in the cities of the three medical schools in Florida to present role models and provide orientation on family practice to medical students.

The Florida Council on Graduate Education for Family Practice and the Florida Association of Family Practice Residents meet regularly during Family Practice Weekends and permit easy interaction with the Academy. Close liaison is maintained between the Academy and the Community Hospital Education Council, an agency of the State of Florida. An annual legislative reception in Tallahassee attempts to keep Florida's lawmakers informed on the progress of family practice training in the state.

The Florida Academy of Family Physicians and its members participate actively with the Florida Medical Association for the continuing improvement of the health of the people of Florida and the enhancement of the medical profession. The position of Floridians in the American Academy of Family Physicians is substantial and foretells continuing growth of the specialty of family practice.

Six thousand, five hundred and thirty one physicians

Presidents of the Florida Academy of Family Physicians	
1972	Thomas M. Quehl, M.D., St. Petersburg (Deceased)
1973	Norman F. Coulter, M.D., Orlando
1974	Joseph P. Hendrix, M.D., Port St. Joe
1975	Donald G. Nikolaus, M.D., Dunedin
1976	Thomas B. Thames, M.D., Orlando
1977	Dick L. Van Eldik, M.D., Lake Worth
1978	Bernard Kimmel, M.D., West Palm Beach
1979	Charles A. Dunn, M.D., Miami
1980	Kenneth C. Kiehl, M.D., Sarasota

are in training today in the United States in 382 approved family practice residency programs. One hundred eighty-eight young physicians are in the focus of the eight family practice residencies in the community hospitals of Florida. Eleven examinations for diplomate status in the American Board of Family Practice have been held, and more than 22,000 diplomates have been certified in the specialty of family practice. Nine hundred and fifteen are Florida physicians.

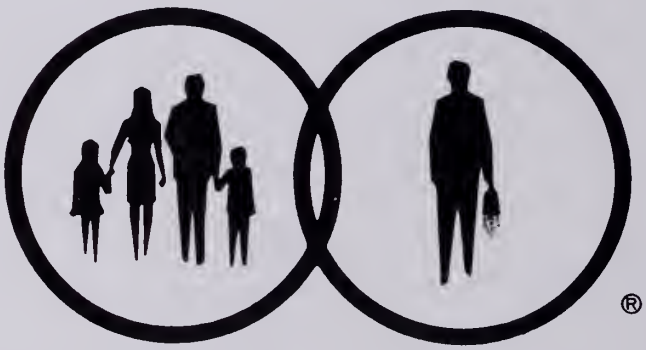
Tomorrow

The scope and character of family practice now are etched in the works of organized medicine and medical education in the United States. Family physicians are taking their useful place in the medical care delivery system in increasing numbers as the American public has the option of access to a scientifically oriented, well trained version of the generalist of the past. Medical care patterned to the needs of the whole patient could continue to appeal to the American public.

Family practice educators and their colleagues in all related medical specialties will continue to seek out better methods of patient care and better ways to train young physicians for family practice. Formalized programs of continuing medical education will remain a vital part of the family physician's professional life.

Family physicians, individually and collectively, will assume increasing public advocacy in all health-related matters and will be placed in roles as spokesmen for the medical profession to government and the public because of their overview position within medicine and the development of their interpersonal skills.

Excellence and dedication are very personal things. They will define the ultimate limits of the horizon for the family physician of the future.



Partnerships for the Future In Preventive Health Care (Turn Around, Look At Us)

Boyd E. McCracken, M.D.

Abstract: This paper is based on findings of the 1979 Lifestyles/Personal Health Care in Different Occupations Study carried out by the American Academy of Family Physicians. Evidence has been found that physicians must assist the public to accept individual responsibility in their personal health care. By focusing more attention on patterns of living, lifestyles, habits, and causes of stress, physicians can effectively motivate individuals to bring about change in their living pattern when change is needed. This concept requires emphasis on preventive health care. To accomplish these goals effectively, the physician must first look at his own attitudes, beliefs, and practices. He must recognize his preceptorship responsibilities.

"He that will not apply new remedies must expect new evils"—Bacon

Believing that "wellness" care is as important as "sickness" care and that greater emphasis needs to be placed on preventive aspects of health care, the American Academy of Family Physicians carried out a study in 1979 on Lifestyles/Personal Health Care in Different Occupations.[1] (See Appendix for a brief description of that study.)

One of the basic premises held at the outset of this study was that prolongation of life in and of itself was not a sufficient goal to be pursued. Rather, improved quality of life and joy of living were goals to be sought as life expectancy increases.

A goal of the study was to attempt to obtain answers to such questions as: How well do physicians understand the role that their patients' lifestyles play in their overall health? Are physicians as effective as they should be in aiding their patients to make changes in their living habits when change is needed? Do physicians apply the principles of preventive health care to the degree necessary to lessen the health risks of their patients?

The American Academy of Family Physicians embarked on this study because it was felt that family physicians needed more information concerning prevailing attitudes and health habits in order to increase the effectiveness of the total health care they provide for their patients.

Commenting on this study, *Patient Care* Editor Herrick Peterson stated: "The importance of the workplace as a generator of stress can be clearly drawn from the report. The interrelationships among health, home, work, and sex life stresses as shown by the study point not only to the need for physicians to consider these factors more heavily, but for further study of these factors in all walks of life.

Another implication of the study deserving serious consideration by all physicians is that examination of one's own attitudes in comparison with others' may open avenues of communication and areas of understanding."[2]

In "A Positive Strategy for the Nation's Health", Lester Breslow, M.D., MPH, stated: "Evidence is accumulating that it is not race or religion per se that is largely responsible for health in America today. Rather, it is particular features of our lifestyle. The pattern of daily living, including eating, physical activity, use of alcohol and cigarettes, largely determines both health and how long one lives."[3]

With the publication in 1979 of the Surgeon General's Report on Health Promotion and Disease Prevention, "Healthy People",[4] there was an important review of the dramatic reduction in mortality rates that had occured in the last decade.

This document clearly lays out the concept of individual responsibility in preventive health care. It further points out that multiple approaches will be utilized to achieve the goal of an ever healthier America. A grave responsibility is thereby placed on the medical

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profession, for if it does not grasp this opportunity to guide an enlightened public, others outside the profession will do it.

The Lifestyles/Personal Health Care in Different Occupations Study of attitudes and practices included randomized, carefully prepared questionnaires submitted to representatives of six occupational groups: the American Management Association, the National Grange, the International Ladies' Garment Workers Union, The National Secretaries Association, the American Federation of Teachers, and the American Academy of Family Physicians.

The study report stated at its beginning: "In this initial phase of what we conceive to be an ongoing study, it has not been possible to produce 'final' scientific answers to a host of very complex questions. Rather, it has been our aim to gather pertinent data on a variety of subjects of growing concern to the American people, data we hope will prove helpful to all those who would find better ways of making our lives both happier and healthier."

This data is not presented as depicting "the public." Rather, it has attempted to compare findings about individuals in the organizations represented. However, it is believed the participating organizations have certain representative qualities. Three of the organizations are made up primarily of women, representing factory workers, teachers, and secretaries. Three are made up primarily of men, representing executives, farmers, and physicians. A broad spectrum of social and economic backgrounds are therefore involved.

Some of the suggestions that emanate from this study include: 1) The medical profession must pay greater attention to the patient's workplace and the stress it creates; 2) There is a persistence of the old fashioned "work ethic" and a belief that stress on the job is a normal part of our working lives; 3) Greater self-fulfillment and appreciation are as important as a greater salary for people to consider changing jobs; 4) There is a major gap between belief in the importance of healthy habits and the actual performance of them.

The primary purpose of this paper is to take a closer look at family physicians' attitudes compared with those of individuals in other occupations. The findings serve as a guide to show where changes in behavior will lead to increased physician effectiveness.

Physicians as Patients

The respondents in the study were asked if they have a personal physician. For the entire group, 85% responded affirmatively, but only 57% of the family physicians polled indicated having their own doctor.

When asked, "In the past five years, how many complete medical examinations have you had?", 22% of the physicians replied, "none." Whereas, 35% of all respondents had had four or more exams, only 13% of the FP's matched this performance.

Using this as a measure of performance, these data indicate that family physicians do not set a good example for their patients. In this and other questions asked of physicians it appears that many treat themselves. This is reminiscent of the old adage that "the physician who treats himself has a fool for a patient."

Satisfaction with Physicians

Few people (1.5%) reported being not at all satisfied with their doctors' services. However, a significant 41% of all respondents (excluding the physicians themselves) reported being only fairly or moderately satisfied with their doctors' services . . . The remaining 57.5% reported being very satisfied.

Fewer people were satisfied with their doctor's interest than with his services. Leaving the physicians' responses out of the equation, 4.5% of those polled were not at all satisfied. Individuals being only fairly or moderately satisfied with the physician's interest amounted to 44%. The remaining 51.5% were satisfied on this score.

How well do physicians communicate with their patients in explaining details of diagnosis and treatment? In the minds of 7% of the respondents other than physicians, their doctor never or rarely explains adequately; reporting that he/she does so "sometimes" were 14%. However, 79% stated that their doctor does so usually or always.

From these responses comes the implication that physicians should demonstrate more interest and communicate explanations of diagnosis and treatment more clearly to their patients.

The various mechanisms used to cope with stress will be discussed later in this paper. However, utilization of physician counseling in coping with stress occurred to only a limited degree, according to the respondents. Talking to their physician as a means of dealing with stress was carried out by only 4%. The range by groups utilizing this method varied from over 7% for the garment workers to less than 2% by executives.

It appears that physicians could practice better preventive health care if they developed greater understanding of the negative impact that stress can have on their patients and if they created more opportunities for their patients to discuss their problems.

In order to place the physician into perspective regarding his attitudes and beliefs as compared with others, a composite of the typical family physician in this study will be utilized.

Composite Family Physician

The typical member of the American Academy of Family Physicians as drawn from this study is a married,

49 year old, overweight, white male who is content with his living arrangement and enjoys his practice of medicine despite considerable pressure from it. He feels a sense of fulfillment from being appreciated in his work and he spends as much time as possible with his family.

Obesity is a concern to him since he realizes that 61% of his fellow M.D.'s should lose at least 10 pounds and that a fourth of them feel the need to lose more than that. These figures compare closely to the aggregate for all groups with 63% wanting to lose at least 10 pounds and 28% wanting to lose more than that. Unfortunately, 89% of the typical physician's colleagues and 91% of all groups tested have made no attempt to lose weight by dieting in the six months just preceding completion of the questionnaire.

Of those who did diet to lose weight, physicians did a little better than the others, with 62% losing weight successfully and 27% losing weight but then regaining some or all of it. For the entire study group, less than 46% lost weight with an additional 40% losing weight, then regaining.

The medical profession cannot be very proud of its record in decreasing the incidence of obesity as a major public health problem. The concept of physicians leading by example might apply effectively here, for they might be better able to motivate patients to lose weight if they were not overweight themselves.

The composite doctor considers himself to be religious and manages to attend church services once or twice a month, but he notes that although 30% of his cohorts do not consider themselves to be religious, only 17% actually never attend church. There are more executives and teachers than there are physicians who do not consider themselves to be religiously oriented, but farmers, secretaries and garment workers show more marked religious attitudes than those held by physicians.

The typical physician averages six to seven hours sleep at night and finds that his colleagues, as a group, manage to get by on less sleep than do any of the others.

Physicians at Work

It is surprising to find that 35% of the doctors work more than 60 hours per week, while in the two other predominantly male groups, 16% of the executives and 23% of the farmers work as many hours. The three predominantly female groups average only 3% of their numbers who spend an equivalent amount of time at their place of employment.

The typical physician misses less work due to illness than any of the other groups queried. Regarding the number of work days missed because of illness in the year preceding completion of the questionnaire, only 4% of the typical physician's medical colleagues missed more than 10 days. This was less than any other group. For all of the groups, an aggregate of 44% missed no work at all, while over 64% of the doctors reported missing no work in that year's time.

The composite doctor likes his work, he is happy with his work environment, but he feels stress from his practice. That he experiences stress is consistent with the overall theme emanating from this study, indicating that stress, in and of itself, is not a cause of unhappiness. The problem arises in how one handles stress.

In regard to how well the other groups like their work and their contentment with their work environment, there is a considerable difference between the predominantly male groups and those composed mostly of women. Farmers and executives join physicians in making up a composite of over 95% who usually or always like their work, and over 96% who usually or always like their work environment. The predominantly female groups, however, report only 85% who like their work usually or always and 88% who are happy with their work environment. The ladies in garment work are the least happy with their employment. Factors concerning work satisfaction are illustrated in Figure 1.

In regard to the stressfulness of their work environment, there is a considerable difference by occupation. Executives exceed physicians in finding their work usually or always stressful, with 81% compared to the doctors' 65%. Farmers like the work they do at a reported 97%, but only 38% find their work usually or always stressful. For the groups made up mostly of women, stress being usually or always present varies

FIGURE 1

WORK SATISFACTION



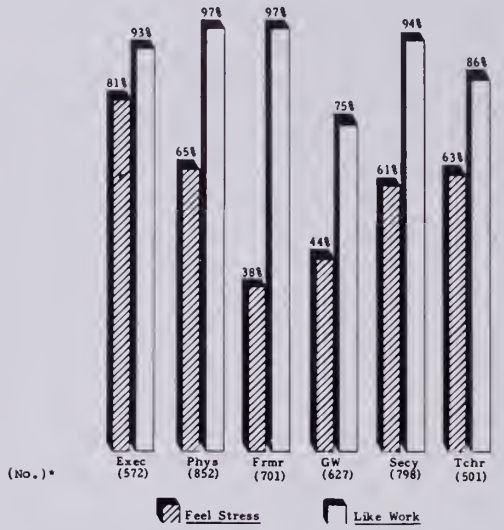
FIGURE 2

STRESS AND SATISFACTION — WORK/HOME/STRESS

"How stressful is your work environment?"

"Do you like the work that you do?"

- % of total respondents who say "usually" or "always."



* There were slight but insignificant differences in the numbers answering each of these two questions. Numbers given in every case represent the lowest figure of the two.

From AAFP Lifestyles/Personal Health care in Different Occupations

TABLE 1

LEADING FACTORS (TOP 3) IN: WORK/HOME/STRESS

-% of total respondents who checked the following:

JOB STRESS	JOB UNHAPPINESS	CHANGE LINE OF WORK
Business Executives		
(58%) DEADLINES*	(13%) Appreciation	(51%) FULFILLMENT
(45%) WORKLOAD	(9%) Salary	(23%) SALARY
(33%) SUPERIORS	(Advancement	(10%) Pressure
	(8%) (Boredom	
	(Personality	
Family Physicians		
(49%) WORKLOAD	(8%) Overtime	(32%) PRESSURE
(25%) DEADLINES	(Appreciation	(31%) FULFILLMENT
(7%) Personality	(5%) (Salary	(10%) (Location
	(Boredom	(Salary
	(Personality	
Farmers		
(21%) WORKLOAD	(8%) (Appreciation	(34%) SALARY
(15%) Deadline	(Salary	(27%) FULFILLMENT
(10%) Salary	(5%) Advancement	(17%) Pressure
Garment Workers		
(25%) SALARY	(22%) SALARY	(56%) SALARY
(15%) Superiors	(17%) Appreciation	(18%) Fulfillment
(11%) Workload	(15%) Advancement	(14%) Pressure
Secretaries		
(48%) WORKLOAD	(19%) Advancement	(46%) FULFILLMENT
(46%) DEADLINES	(15%) (Appreciation	(33%) SALARY
(22%) SUPERIORS	(Salary	(8%) Pressure
Teachers		
(38%) WORKLOAD	(24%) APPRECIATION	(36%) FULFILLMENT
(27%) DEADLINES	(19%) Salary	(30%) SALARY
(24%) SUPERIORS	(14%) (Advancement	(10%) Pressure
(24%) SALARY	(Work Conditions	

* Factors in upper-case checked by 20% or more of respondents

From AAFP Lifestyles/Personal Health Care in Different Occupations

from 44% for the garment workers to 63% for the teachers. Figure 2 compares factors of stress and satisfaction according to the different occupations.

The composite doctor finds that the main cause of the stress he feels in his work comes from excessive work load; meeting deadlines is the next most common cause. The breakdown for all of the groups in regard to causes of stress is shown in Table 1. This Table summarizes and compares job stress, job unhappiness, and factors that cause individuals to consider changing their line of work.

Mental Outlook

The typical physician manages to be optimistic about the future and is not subject to depression. He does notice a considerable difference in these areas between the predominantly male groups and those composed mostly of women. Combining doctors, executives, and farmers, only 10% feel blue or worried much of the time. By contrast, 25% of the combination of teachers, garment workers, and secretaries are worried or feel blue much of the time.

A similar finding is present in the percentages of those who had been depressed in the month preceding submission of the questionnaire. An average of 7% of the doctors, executives, and farmers reported being depressed. An average of 17% of the secretaries, teachers, and garment workers were depressed during the same period.

The majority of the respondents were optimistic. However, physicians should note the frequency with which pessimism and depression were reported, particularly by women, and be guided by these findings in their preventive health efforts.

Physicians at Home

The typical physician is content with his present home. Each week he spends 10 to 20 hours with his family; he spends less than 10 hours watching television, and about the same time reading. He spends less than 5 hours per week with a hobby.

The majority of all the groups are content with their living arrangements. Individuals in all of the other groups spend more time with their families than physicians do, with 35% of the physicians spending more than 20 hours per week as compared to 48% for all groups.

Doctors spend much less time watching television than any of the other groups, with 60% reporting watching TV less than 6 hours per week. By contrast, a majority of the entire sample spend more than 6 hours per week in front of the TV.

The responding physicians read more than any of the other groups but they match the others in the amount of time spent with hobbies, less than 6 hours per week for 72%.

The respondents were queried as to the amount of time they spend helping with housekeeping chores. The typical FP helps with the marketing, finds time to do some gardening, and rather regularly takes out the garbage.

He does less than his executive and farmer counterparts in helping with the laundry, cooking, dishwashing, and housecleaning. (If these statistics help the reader get out of doing any of these jobs around home, please let the author know.)

Dr. Typical does better than the others in only one area, that of helping take care of the children. Physicians record 38% in this task as compared with 33% for all others.

Problems at Home

The typical physician from the study doesn't have many significant problems at home. He lives with his spouse and children fairly contentedly. However, as a group, his colleagues report more personality conflicts with spouses or living partners, more sexual dissatisfaction, and more problems with the children than is reported by the aggregate. One or more of these problems are reported by 43% of the physician group as compared to 35% for the entire study population.

Physicians as a group have fewer problems than the average for all groups in several areas. They report less interference by parents or in-laws, less loneliness, and less fear of crime, illnesses, and accidents than is seen in the averages for all groups.

The three groups made up mainly of women contrasted strikingly with the three predominantly male groups in regard to problems of loneliness, fear of crime, and fear of illness or accident. Loneliness was expressed by 13% of the female groups while the male groups tallied 5%. Fear of crime is a greater problem among the women as recorded by more than 7.5%, compared to under 3% in the male groups. The garment workers stood out prominently; over 10% reported fear of crime.

Fear of crime can be compared to the results of a question on having been the victim of a serious crime. Doctors have been the victim more than any of the other groups with 29% reporting this experience. The overall average was 20%, but despite their greater fear, the garment workers had the lowest rate of victimization at just over 12%.

Fear of accidents or illnesses was an even greater concern for the garment workers, with 15% reporting this worry. The average for all three mainly female groups was less than 10%, while the male counterparts recorded 4.5%.

Physicians should note the frequency of loneliness, fear of crime, and fear of accident or illness herein reported, particularly by women in the study.

Coping with Stress

The relative infrequency with which the respondents counsel with their physicians in coping with stress was cited previously in this paper.

Methods utilized in coping with stress by the respondents in this study may aid physicians in developing insights that can be of help to them in dealing with their patients.

Table 2 identifies the top five activities for coping with stress reported by each group in the study. Methods reported by more than 20% in each case are shown in upper case type.

The typical physician frequently uses exercise as a means of coping with stress; talking to a friend and meditation are mechanisms he may also use.

He also believes that exercise is important to his health. This opinion is shared by 95% of his colleagues as well as by 93% of all groups in the study.

The typical physician exercises less often than he believes he should. Of his fellow physicians who participated in the study, 67% participate in more than one exercise session per week. This amount of exercise is better than that reported by the aggregate in which only 52% achieve even this frequency of exercise.

The composite doctor uses walking as his main form of exercise as do 59% of his colleagues. Almost 27% of the physician group are involved with jogging, compared to 15% for all groups. Figure 3 reflects the frequency with which various forms of exercise are utilized by physicians

TABLE 2

COPING WITH STRESS — WORK/HOME/STRESS

"Which of the following do you do to cope with stress?"

-Top five activities for each group, with % of total respondents who indicate each activity.

Executives		Garment Workers	
(48%)	EXERCISE*	(47%)	TALK
(38%)	TALK	(19%)	Eat
(23%)	MEDITATE	(17%)	Smoke
(21%)	EAT	(16%)	Meditate
	(Sex	(12%)	Exercise
(19%)	(Alcohol		
	(Smoke cigarettes		

Physicians		Secretaries	
(49%)	EXERCISE	(66%)	TALK
(33%)	TALK	(30%)	EAT
(27%)	MEDITATE	(26%)	EXERCISE
(22%)	EAT	(20%)	MEDITATE
(19%)	Sex	(18%)	Smoke cigarettes

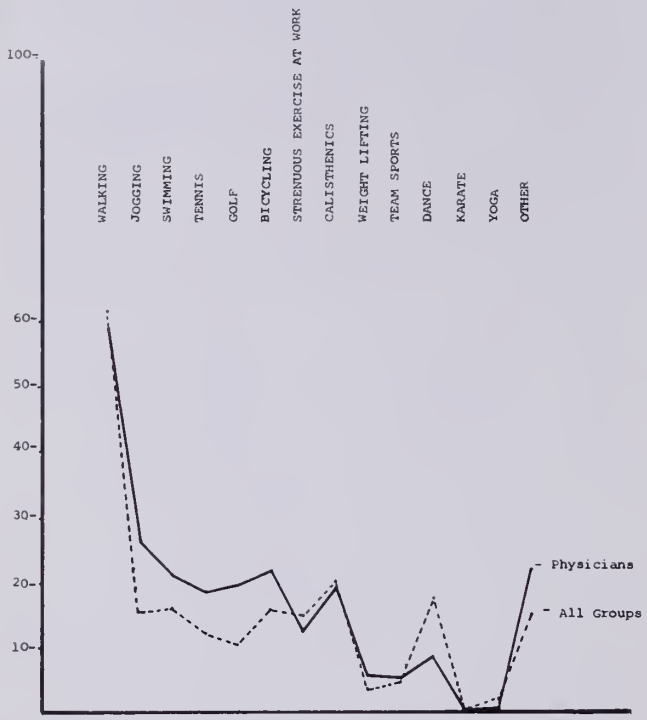
Farmers		Teachers	
(36%)	TALK	(64%)	TALK
(20%)	MEDITATE	(34%)	EAT
(20%)	EXERCISE	(30%)	EXERCISE
(15%)	Eat		(Meditate
(10%)	Sex	(17%)	(Smoke cigarettes
			(Take it out on others

* Activities in upper-case checked by 20% or more of respondents

From AAFP Lifestyles/Personal Health Care in Different Occupations

FIGURE 3

FREQUENCY OF EXERCISE



From AAFP Lifestyles/Personal Health care in Different Occupations

as compared to the combined pattern for all groups.

Sexual Attitudes, Beliefs, and Practices

The typical physician in the study is satisfied with his sex life, he feels that sex is necessary for happiness, and he has sexual intercourse one or two times per week. Among his medical colleagues, 5% report that they have intercourse five or more times per week. They are more active sexually than the other groups in the study. Figure 4 shows a comparison between the attitudes of physicians and the total group.

Figure 5 compares attitudes on homosexuality and extramarital sex between physicians and the total group.

Questions relating to sexual matters were not submitted to the garment workers at the request of their union.

Cigarette Smoking

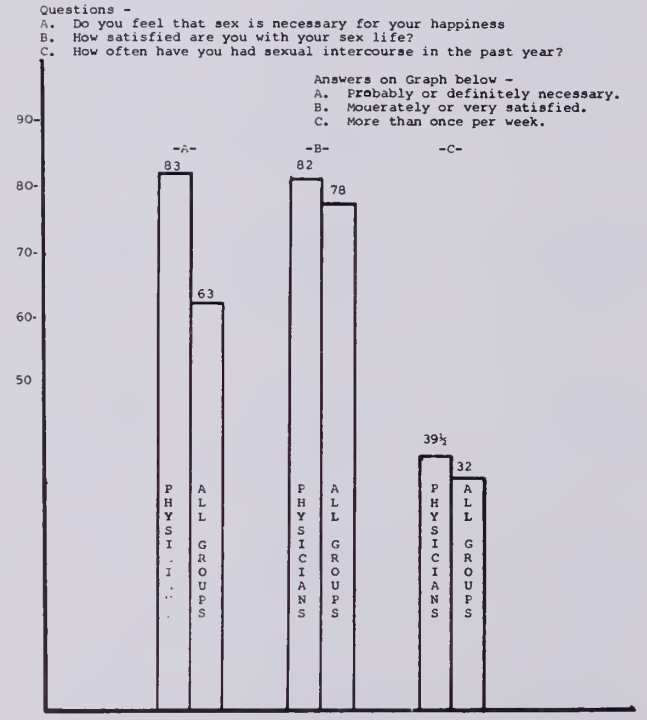
Questions on tobacco smoking in the study were limited to cigarettes on advice of our consultants in the specialty of Prospective Medicine.[5]

The typical family physician does not smoke cigarettes. He finds that only 14% of his colleagues smoke; those who have smoked and quit total 43%, while 42% have never used cigarettes.

Figure 6 depicts some of the cigarette smoking data obtained in the study.

FIGURE 4

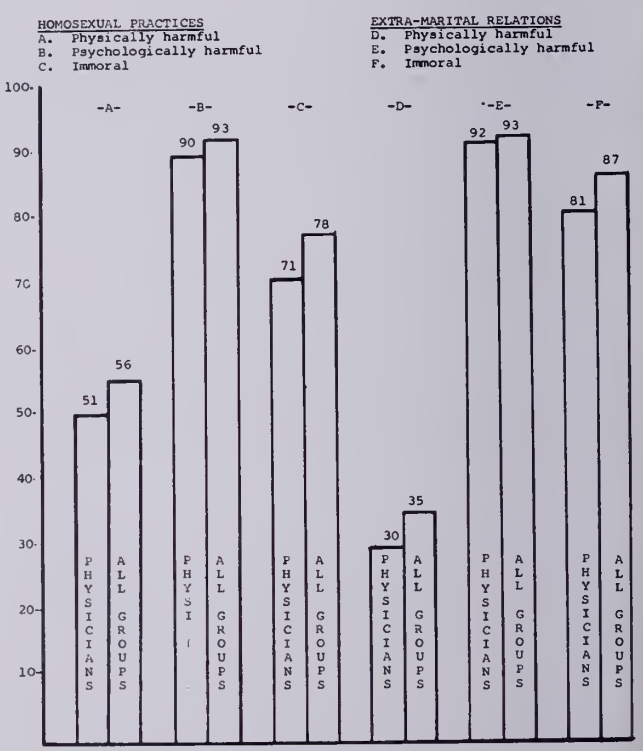
SEXUAL ATTITUDES



From AAFP Lifestyles/Personal Health Care in Different Occupations

FIGURE 5

SEXUAL ATTITUDES



From AAFP Lifestyles/Personal Health Care in Different Occupations

The attitude of the study groups toward non-smokers' rights was investigated by a question asking the respondents if they believe that non-smokers have a right to ask smokers in public places to put out their cigarettes.

The results from all of the groups were close with 77% of the M.D.'s saying probably or definitely yes and 74% of the entire study group reflecting the same attitude.

Alcohol

The typical doctor takes fewer than seven alcoholic drinks per week and practically never drinks alone. About 14 in a hundred of his colleagues never partake of alcoholic beverages. Drinking, up to a maximum of 6 drinks per week, is reported by 64% of the physicians.

An interesting range was observed in regard to total abstinence for all of the groups with only 9% of the executives but 45% of the garment workers never drinking alcoholic beverages.

Secretaries and teachers reported that 18% from each group never drink.

Physicians appear to believe that alcohol is probably or definitely physically harmful with 90% so reporting. The total sample shared this attitude with 85% agreeing.

From the psychological standpoint, 86% of the doctors consider drinking alcohol probably or definitely harmful. In the entire group 77% share this belief.

FIGURE 6

CIGARETTES — LIFESTYLES

- "Do you smoke cigarettes?"
- "Are you an ex-smoker?"



Note: The figures for those who have "never smoked" were arrived at by subtracting the smokers and ex-smokers from all the respondents who answered the questions on smoking cigarettes.

From AAFP Lifestyles/Personal Health Care in Different Occupations

On the other hand, drinking is not so often perceived by physicians as a moral problem, with 71% saying it is probably or definitely not immoral. A smaller segment of the entire group, 61%, believe that it is not immoral.

It would appear that family physicians usually are temperate in their personal use of alcohol. They consider its use to be of more potential harm physically and psychologically than a problem of immorality.

Marijuana

The extent that marijuana is used by physicians is small with a little over 4% occasionally partaking. About the same percentage of the other groups use marijuana with the exception of teachers who report about 11% to at least occasionally indulge.

The breakdown according to attitudes and beliefs about marijuana shows a considerable variation in opinions by physicians and the others as to the effects it can have on work, family life, and general well-being.

In the following categories, the first figure represents physicians' responses and the parenthesized percentages are those recorded for the all-group averages. Those persons who feel marijuana has no effect just topped 15% (12%); those who feel it may be beneficial made up 11% (7%); those who think it has mixed beneficial and harmful effects made up 36% (25%); and those who think marijuana is harmful made up 38% (56%).

Doctors seem to be less convinced than others polled that marijuana is harmful.

Hard Drugs

In regard to hard drugs, 95% of the physicians have never used any of them while 5% have. These figures can be compared to 97% of the entire group having never used these substances while 3% have.

Health Problems and Medications

In the month prior to completion of the questionnaire, the typical family physician had not any health problems included in a selected list in the inquiry: headaches, muscle aches or tension, backaches, anxiety or nervousness, insomnia, depression, or constipation.

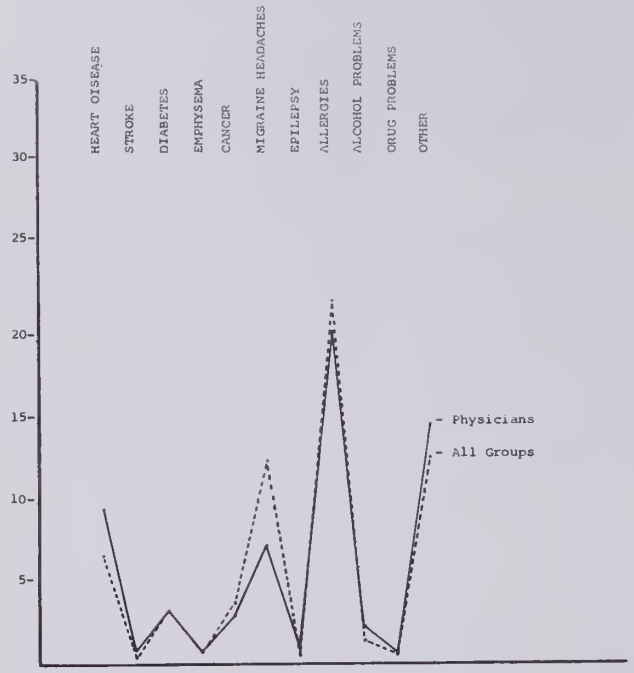
He had not ever had any medical problems listed in the questionnaire: heart disease, stroke, diabetes, emphysema, any form of cancer, migraine headache, epilepsy, allergies, problems with alcohol, problems with other drugs, other problems.

Responses to questions on prior serious medical illnesses are shown in Figure 7. It will be noted that the experience for physicians closely resembles the aggregate.

Figure 8 shows the percentage of health problems or symptoms in the month prior to completion of the questionnaire. It will be found that physicians had significantly fewer problems than the entire group.

FIGURE 7

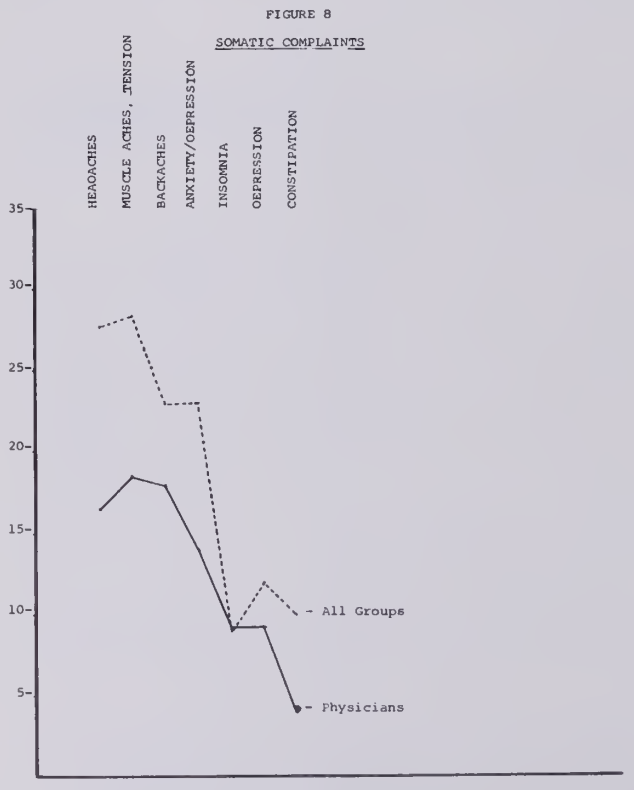
MEDICAL ILLNESSES



From AAFP Lifestyles/Personal Health Care in Different Occupations

FIGURE 8

SOMATIC COMPLAINTS



From AAFP Lifestyles/Personal Health Care in Different Occupations

Physicians might take note of the frequency of somatic complaints and help their patients deal with these kinds of problems since they may be stress-related.

Despite a significant number of perceived minor ailments, use of medications is surprisingly low. Antihistamines are used most commonly with 9% of physicians and 10% of the entire sampling using these preparations.

Aside from tranquilizers or sedatives at just under 3% for physicians and just over 3% for the entire group, and for pain pills at 2.5% for physicians and a little over 6% for the group as a whole, no other medications listed were used by as many as 2% of those reporting. Therefore, the use of mood elevators, pep or diet pills, sleeping pills, or other "nerve" pills was uniformally low.

Summary

Awareness of the health hazards associated with inappropriate patterns of living, lifestyles, and habits and finding ways to help patients accomplish change where needed represent major responsibilities for the medical profession in the 1980's. With those goals in mind the author has tried to summarize some of the findings of the AAFP 1979 Lifestyles/Personal Health Care in Different Occupations Study.

For physicians effectively to motivate their patients toward healthier living patterns, they must first look at their own performance. In this paper a frame of reference was utilized that consisted of comparing physicians' lives with the lives of others. A composite of the typical family physician as found in the study has been utilized for this comparison.

It is hoped that this first effort in an on-going study will, at least, serve as a guide to determine directions to be taken by other comprehensive efforts.

Conclusions

Stress is more often associated with the work-place than the home. Greater personal achievement, sense of fulfillment, and being appreciated are more important factors in happiness than is avoidance of stress. Great stress is often acceptable if it will lead to attainment of these goals.

Greater attention should be given by physicians to their patients' coping needs. Physicians need to be more understanding of and available to their patients when these needs exist. Particular attention should be paid to their patients' fears of crime, illness, and accident.

It is by better understanding himself and by comprehending the impact that adverse living patterns can have on all of us that the physician develops insights necessary to work most effectively.

References available from the author upon request.

• Dr. McCracken, 100 North Locust Street, Greenville, Illinois 62246.

APPENDIX

METHODOLOGY

AAFP LIFESTYLES/PERSONAL HEALTH CARE IN DIFFERENT OCCUPATIONS

In December, 1978 and January, 1979, Research & Forecasts, Inc. sent a 4-page questionnaire to a systematically selected sample of the American members of different occupational groups. The groups sampled were:

- **American Management Associations**—An association of managers in industry, commerce, government, and non-profit organizations, administrators and university teachers of management. (71,000 members).
- **American Academy of Family Physicians**—A professional society of family physicians, not limited to one field of medicine or surgery, who provide continuing comprehensive care to the patient, (48,000 members).
- **National Grange**—A fraternal organization of rural families, many of whom are farmers. (500,000 members).
- **International Ladies' Garment Workers Union**—A union of garment workers. (350,000 members).
- **The National Secretaries Association** (International)—A professional organization of secretaries. (38,000 members).
- **American Federation of Teachers**—A union of teachers. (500,000 members). (For this study, only AFT non-university level teachers were mailed the questionnaire).

The study sought to survey Americans representing many different walks of life, diverse income levels, and educational backgrounds. The groups also were chosen to give a roughly equal distribution of males and females. Farmers, executives, and doctors are mostly male; the secretaries, and garment workers are mostly female, as are two-thirds of the teachers.

The 72-question survey instrument was developed by the staff at Research & Forecasts, along with social scientists, leading family physicians, and doctors in prospective medicine, statisticians, and communications professionals. The questionnaire contained questions on nutrition, and weight control, exercise, medical care, work environment, home environment, tobacco, alcohol, marijuana, and other drugs, sexual activity and demographics. Many of these, of course, are questions frequently asked by a family physician during a periodic health examination.

The ILGWU requested that the section on sexual activity be deleted from the questionnaire sent to its members.

The questionnaire was mailed out in early December, 1978, followed by a reminder postcard a week later. A second copy of the questionnaire was sent to each sample in early January, 1979.

To obtain a sample size of about 1,500 for each occupational group, Research & Forecasts advised each association on how to derive a systematically selected sample from its membership lists. The size of the association was divided by 1,500, resulting in "N". Then, every "Nth" person was selected from the lists.

The number of returns and the percentage for each organization are shown in the table below:

Association	Sample Size	Number of Responses	Percent
Executives	1341	584	43%
Physicians	1575	872	55%
Farmers	1900	844	44%
Garment Workers	2100	794	37%
Secretaries	1500	846	56%
Teachers	1446	533	36%

Somewhat larger samples of garment workers and farmers were chosen because the sponsoring group cautioned that their members were not prone to answering questionnaires. A test for non-response bias (computer comparison of responses given by early and late respondents) revealed no significant bias.

Basic demographics of the respondents correspond to demographic data for the entire membership of their respective groups, indicating that the sample is an accurate representation of the different association memberships.

Data processing was handled by Calculogic Corporation, New York, which also provided methodological consultation.

Dr. Edward Lehman, Chairman of the Sociology Department at New York University, served as research consultant throughout the formulation and execution of this study.

Consultants in the formulation of the questionnaire and project development also included:

Dr. Jack Hall—Assistant Dean, School of Medicine, Indiana University.
Dr. Ronald Blankenbaker—Chairman, Department of Family Medicine, University of South Florida.
Dr. Charles Ross—President, Interhealth, Inc., a subsidiary of Control Data Corporation.
Mr. Lee Kremer—Vice President, Health Systems, Control Data Corporation.
Ms. Carolyn Kuhn—Project Manager of Health Systems, Control Data Corporation.
Dr. Paul Gebhard—Director, Institute for Sex Research, Indiana University.

Family Interactions in Family Practice

Frederick Firestone, M.D. and Martin Denker, M.D.

Our hypothesis is that today's family physician is a major resource to patients undergoing psychological stress. Research indicated that many medical problems brought to family physicians derive from improper family interaction. Psychological and interpersonal disturbances in families become physical diseases. These changes are presented to the family physician as medical problems, but they often may not exhibit the severity or predictability or codable disease entities. These problems present unique diagnostic and treatment difficulties. Also unique is the opportunity presented to the physician who is alert to the importance of family interaction in the practice of medicine.

There is historical precedent for this idea. The old general practitioner of yesteryear had only a few therapeutic regimens and drugs available; however, by following many members of the same family for most of their lives, he gained detailed knowledge of the whole family and its interactions. This close association with the family provided important diagnostic and treatment tools that too many contemporary practitioners have forgotten.

Today's primary care physician too often looks to isolate a problem as the first step in solving it rather than looking beyond the individual patient for possible precipitating factors.

The idea of a family interview before patients are accepted for treatment has taken hold. Increasing numbers of family physicians require these interviews.

To prove that a family interview has merit and can bring about facts which may be important when attending family members, the following study was done.

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Methods

A questionnaire survey method was chosen for the first examination of the hypothesis that family physicians are a major source of assistance to many persons in time of emotional crisis. We wanted to determine if there is sufficient supporting evidence to investigate the problems further. In some respects, this is a formal way of recording clinicians' impressions of the problems brought to them by patients. We determined that a large number and wide range of responses would be taken as an indication that the hypothesis needed to be re-examined or dropped.

Two questionnaires (Tables 1 and 2) were distributed to more than 250 parents with teenage children or to teenage children themselves who had consecutive appointments in a busy, middle-class family practice. These parents and teenagers were given the questionnaire with a self-addressed envelope and requested to complete the form and return it unsigned. We hoped that confidentiality would promote accuracy and honesty. One hundred twenty four, questionnaires were returned. Fifty two came from teenagers and 72 from parents.

Table 1

Family Medicine Questionnaire for Children and Young Adults

Some of the most important problems for children and young adults come from how well or how poorly they are getting along with their parents. Below is the list of common problems of this nature. If your parents were to suggest that you talk to your family doctor about one of these problems, which one(s) would you be willing to talk to him or her about?

Circle one of the letters below. If you would be willing to circle more than one of the letters, put a number next to the circle in the order in which you would like to discuss these things (1, 2, or 3).

a) Less supervision
b) Parents do not understand you-we are not close enough (generation gap)
c) Less work at home
d) More allowance
e) Less pressure for good grades or homework
f) Permission to come home late
g) Permission to smoke, drink, etc.
h) Dating choice of friends
i) VD and birth control

Children and Young Adult Questionnaires

Over 28% (the largest group) of teenagers felt that their parents did not understand them and that they were not close enough (generation gap); 21% had problems with VD and birth control; 15% wanted less supervision from their parents. Answers to the rest of the problems were each under 10%. (Table 3)

Parent's Questionnaires

Over 27% felt they had a problem with their teenage childrens' drinking, drugs, and smoking (pot) habits, 19.5% had marital problems, 8% had problems with relatives, and another 8% felt the children did not keep their rooms neat. Answers to the rest of the problems were each under 6%. (Table 4)

It seems reasonable to conclude that the return rate and the variety of problems discussed support the hypothesis that the family physician is indeed a major resource for patients undergoing family related emotional crises. Over one-quarter of the parents had problems with their teenage children which they would bring to their family physician. More than 40% of the children had the same response with respect to their parents.

The next biggest problem area was different for parents and for children. One-fifth of the parents listed marital problems as a major area of concern that they would discuss with their family physician. One-fifth of the children would take as their second priority of discussion with their family physician problems concerning sex, birth control, and veneral disease. Other problems reported by either parent or teenager were less than 10%.

Only one questionnaire was returned by parents who stated that they had no problems. One form was returned with only the notation that "it is none of your business." One questionnaire stated that family physicians only cured ill people and did not do any counseling. These comments suggest, in this population, that the notation of a family physician as merely a health technologist is not very prevalent. On the contrary, most respondents viewed the family physician as a major resource to all family members for the most pressing problems in each of their lives.

Discussion

Although it contradicts the current negative media image, the picture that emerges from our study is not surprising. More objective research has indicated that a substantial percentage of the mental health care and psychological/emotional counseling delivered in the United States is delivered by family physicians outside the mental health care system. Thus, even though the population surveyed here is not typical of a broad spectrum of American society, the results are consistent with findings of much larger surveys.

Table 2

Family Medicine Questionnaire for Parents

One of the most important stress factors which determines the health of an individual person comes from how well that person is getting along with the people or persons closest to them.

Below is a list of common problems in personal relationships. If you were to have one or more of these problems, which one(s) would you seek help or advice from your family doctor? If you would talk to him about more than one of these, which would you talk to him about first, second, and third? Circle one letter. If you circle more than one letter, put a number next to it in order of priority (1, 2, or 3) and go to a, b, c, etc., for problems listed.

a) Family problems with relatives (Parents-inlaw, etc.)
b) Marital conflict
c) Problems with children
   1) schoolwork (would like them to have better grades)
   2) dress code
   3) drinking-drugs-smoking pot
   4) keeping room orderly-clean
   5) coming home late at night
   6) not doing his share in housekeeping
   7) dating-sexual behavior

Table 3

Teenager Responses

	Number	Percentage
Less supervision	8	15.4%
Parents do not understand me, we are not close enough	15	28.8%
Less work at home	2	3.8%
More allowance	2	3.8%
Less pressure for good grades or home work	5	9.6%
Permission to come home late	4	7.7%
Permission to smoke, drink	3	5.8%
Dating: choice of friends	2	3.8%
Veneral disease and birth control	11	21.1%
	52	

Table 4

Parents Responses

	Number	Percentage
Family problems with relatives	6	8.3%
Marital conflict	14	19.6%
Problems with children:		
Schoolwork (would like better grades)	4	5.5%
Dress code	1	1.3%
Drinking, drugs, smoking, pot	20	27.7%
Keeping room orderly, clean	6	8.3%
Coming home late at night	1	1.3%
Not doing his or her share in housekeeping	2	2.7%
Dating, sexual behavior	18	25.0%
	72	

It seems that our hypothesis is supported, or, at least, that further work on it is justified. The family physician may well be in a position to be of great help to the family in focusing on some of these problem areas and beginning to deal with them. Because these problems often present themselves first and in an early stage to the family physician, he is in an ideal position to utilize early intervention and prevention to ensure the health of individuals and their families. The alternative in the current health care delivery seems to emphasize diagnosis and treatment of advanced diseases.

While further research will definitely be needed to verify and extend these findings, it seems appropriate to speculate on a preliminary basis that the family physician should look for evidence of major family stresses in his initial diagnostic interviews. In fact, we would recommend that when alcoholism, sexual problems, or teenage acting-out do not emerge in patients' statements or indirect references, the family physician should ask about these problems. He can then be of maximum benefit to his patients and their families.

Conclusion

Today's family physician, and other primary care physicians can benefit from a family interview. This interview can bring out facts which may be the cause of improper family interaction. The results of our study confirmed our hypothesis that family physicians can be a major source of assistance to patients in times of emotional crisis.

References available from the author upon request.

• Dr. Firestone, Box 13, 12901 North 30th Street, Tampa 33612.

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Family Practice Education in State Supported Medical Schools—Problems, Challenges, and Controversies

E. Scott Medley, M.D.

Abstract: Growth and status of family practice education are reviewed. Common problems in family practice education in general are discussed and contrasted with special problems, advantages, challenges, and controversies in family practice education in medical schools.

Early Development of the Specialty

Reasons and methods for establishment, phenomenal growth, and current status of family practice education was reviewed by Plyler in 1979.[1] The history of the development of family practice residency programs is a story familiar to many.

The Flexner report of 1910[2] urged the reformation of the scientific base for medical education. There followed a decline in the numbers, distribution, and prestige of the general practitioner over the next 50 years. Then in the mid 1960's the Willard Report[3] pointed out the need for family practice residencies and departments of Family Practice in medical schools and was complemented by the Millis Report[4] which condemned the disparity between the numbers of specialists and generalists. Finally, all of these forces combined to lead to the establishment of the American Board of Family Practice and, therefore, residency training and Board certification for family physicians.

These developments had great impact on family practice education in the medical schools as the number of family practice residencies grew in 11 years from about 15 to over 394, the number of departments and divisions of Family Practice in medical schools grew from a handful to more than 100, and medical school faculties found themselves having to establish meaningful curricula in family practice for the large number of students now interested in the specialty.

The growth of, and support for, family practice education in the State supported medical school is continuing. The need for more family physicians originally recognized by Willard and Millis have been recently reaffirmed on a national basis by the Graduate Medical Education National Advisory Committee (GMENAC)[5] preliminary report, by a National Academy of Science study,[6] and by a reconvening of the Willard Committee;[7] and on a statewide basis by reports such as one for the State of Florida[8] prepared by Kenneth E. Penrod, Ph.D., Vice Chancellor for Medical and Health Services of the Community Hospital Education Council.

Furthermore, through the controversial Health Professions Education Assistance Act of 1976 (PL94-484), capitation monies for medical schools are linked to requirements in the numbers of residency positions in a primary care specialty. All these factors point to the conclusion that family practice education in the state supported medical schools is here to stay.

To state that there are many universal problems in the education and training of family physicians would be looked on by my residency program director colleagues as the understatement of the decade, I am certain. Since two-thirds of family practice residency programs are in community hospitals, a few general problems will be outlined and contrasted with special family practice educational problems in medical schools.

Challenges Involving The Residency Program

First, the nature of Family Practice education is one of tremendous breadth. This means that many different people with different talents and skills, but also with different priorities and philosophies must be involved in the education of a family physician. This presents a dilemma in community hospital programs, but even a greater one in the university administered program. To provide this necessary educational breadth, every family

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practice residency program must involve resident rotations on other clinical services—most notably Internal Medicine, Pediatrics, Obstetrics-Gynecology, and Surgery. These rotations through "the other person's ball park" invariably present some difficulties for the residency program due to the intricacies of scheduling, liaison, coordination, and conflicting priorities.

These problems are even greater, however, in the university medical center environment. By their very nature and missions, these other specialty services are involved primarily in the training of "their own" residents. They have training priorities established for their residents and often provide care for patients with tertiary care needs.

Beyond these problems, the family practice resident often finds it more difficult to establish his or her own identity on these other clinical services and, in some cases, may even feel like "a fifth wheel" with no real delineated responsibilities or goals for himself or herself. These potential problems make it especially imperative that there exists in the medical school setting clearly defined educational objectives for and expectations of the family practice resident. Another "monkey wrench" thrown into this already complicated morass is, of course, the requirement that the family practice resident return to the Family Practice Center regularly to provide the continuity of care for the resident's patient panel in the Center, a fundamental part of family practice education and patient care.

Advantages To The Residency Program

The obvious advantages to a resident of having rotations on other university medical center rotations is that these rotations are by their nature geared for teaching. There is usually an abundance of patients and pathological conditions. Just as important is the opportunity for interchange with and hopefully the gaining of mutual respect with peers in training in other specialties. Since family practice programs are now attracting top students, the more exposure given to family practice residents by other specialists, the more credibility is given to the family practice residents and to their training programs.

Challenges Involving Medical Student Education

An additional challenge in medical school family practice programs is the obligation to provide a curriculum for medical students. As family practice is recognized as a valid discipline in more and more medical schools, and as student interest in the specialty continues to increase, family practice medical school faculties find themselves wrestling with the problems of finding meaningful rotations for medical students. This includes the development of educational objectives and goals (no small task in itself), coordinating logistical problems in the curriculum, finding suitable primary care settings (often by definition outside the medical center complex) where the medical student can get a realistic view of the specialty, insuring that adequate faculty support is available at each site, and providing evaluation and feedback mechanisms for the students.

Hand in hand with these challenges go the important obligations for medical school faculty to act as advisors for students interested in family practice, as the students attempt to tailor their elective rotations and to choose a residency program. Very often the family practice faculty are the only people in the medical school who are really aware of the intricacies of the family practice residencies and who are familiar with the various residency programs.

In addition, it is important for family physicians to maintain high visibility among the students by presenting didactic lectures, by participation in seminars and other educational activities, and by sponsoring and actively participating in student family practice associations which serve as an additional educational resource, as well as for peer reinforcement groups, for students interested in family practice.

faculty members must take an active role in medical school admissions committees, curriculum committees, and other important decision-making groups. Clearly, the role of the family practice educator in the medical school setting is a multifaceted and complex one but also one filled with a variety of challenges and rewards.

Problems Concerning Faculty

Another universal problem in family practice education is the shortage of adequately trained and experienced faculty. The specialty as an academic discipline is not yet quite old enough to have a wealth of residency trained, Board certified physicians with a few years of clinical experience who are willing to accept faculty positions, nor are there enough older non-residency trained physicians who are willing to give up their practices to take teaching positions. The American Academy of Family Physicians estimates a shortage of 2,000 faculty for family practice residencies. Perhaps because family practice is people-centered and patient-oriented, family doctors want to be "out there seeing patients" rather than somewhat removed from their patients in a teaching situation.

This shortage of faculty may be particularly acute in the Medical Center environment. Family Practice faculty members who also are full-time university faculty must, of course, wrestle with the old "publish or perish" maxim in order to receive promotion in faculty rank and accompanying increases in salary and prestige. This maxim is becoming a little less rigid and a little more controversial; however, as faculty members, while we are cognizant of

the necessity for research and resulting publications, also we strongly feel that recognition should be granted for teaching and patient services, areas in which many family physicians are most talented, effective, and happy. Another problem is that faculty salaries in university medical schools often are lower than in non-university administered programs. Reasons for this include the modest amount of state funding for faculty positions and the fact that in a university environment a salaried full-time member is very often prohibited from deriving any income from a part-time private practice arrangement. Add to these the problems caused by the bureaucracies inherent in most medical schools and the problem of trying to be an effective liaison between the university ("gown") and community physician ("town), and it is not difficult to see why the university administered family practice program has problems recruiting and retaining faculty.

Advantages For Medical School Faculty

But just as there are additional problems for family practice educators in the medical schools, so are there additional advantages and challenges. Among the advantages are the opportunities to interact with highly trained medical specialists and subspecialists, to have collegial relationships with philosophers, ethicists, historians and others who can broaden one's view of medicine, and to be exposed to the latest developments in clinical research and educational methods.

And, of course, the presence of medical students is in the final analysis, a blessing. One can influence the career choice of a student and can role model as the student's link with physicians "in the real world." In the presence of medical students the resident can not only be a student but also a teacher, thus enhancing the resident's interpersonal skills and scholarly attitudes. And just as research and publishing are obligations of the medical school faculty member, so are they enticements to think analytically and scholarly while maintaining ones identity as a practical, "real world" physician.

Problems With Funding

It goes without saying that adequate funding is another problem for medical education in general, for family practice education specifically, and even more specifically, for family practice education in the medical school. Though state and federal funding sources have recently considered funding for family practice and other primary care specialties a top priority, in most states monies are somewhat sparse for providing the facilities, faculty and staff support, equipment, and educational materials necessary for establishment and growth of excellent family practice residency programs. There is no question that family practice residency programs cannot support themselves through patient fee derived income.[9] This fact becomes very apparent in the medical school setting when primarily in-patient or technically-oriented specialties such as internal medicine and gastroenterology can generate large amounts of patient fee income while primarily ambulatory care, non-technically oriented specialties such as family practice, strive just to meet operating costs. Family practice residency programs can probably never be expected to "pay their own way," nor should they be expected to do so.

As in other medical school outpatient settings, the family practice model unit often provides care for large numbers of patients receiving Medicaid and Medicare benefits. Anyone with experience dealing with these third party payors is aware that "allowable" reimbursement dollar amounts are often woefully low and that family physicians are often compensated at a rate much lower than some other specialists, factors which add to the difficulties in funding a program through patient generated revenues.

Future Challenges And Questions

Much has been written about the challenges in family practice education. The consensus seems to be that now that family practice has established a foundation in primary care education and service, the next major priority is for the specialty to become established as an academic and scholarly discipline, especially in the medical school.[10]

But is this emphasis really the next major priority? Could it be that rather than the establishment of academic credibility the most important priority for family practice education should be insuring that high quality, well-trained, cost-containing, sensitive family physicians are made available to the people in all areas of the country? Could it be that overcoming problems of the rising cost of medical care and specialty and geographic maldistribution are more important that establishing academic prestige?

To continue as a specialty, the aim of the family practice movement must include continuing proof that residency trained family practitioners are settling in small towns (greater than 48% of family practice graduates are still settling in communities of less than 25,000 population),[11] that family physicians are not subspecializing and therefore removing themselves from primary care (the overwhelming majority of residency trained family doctors remain in family practice,[12] a fact not true of other specialties),[13] and that the specialty is leading the way in the battle toward cost containment.[14]

Of course, the process of getting the right doctors to the right people must begin in the medical school. There is no doubt about the direct relationship between curriculum time in family practice in medical school and the selection of family practice as a career.[15] In the

academic year 1977-78, of the 9,074 medical students who were graduated from 82 medical schools with family practice in the curricula, 1,438 (15.8%) chose family practice as their specialty. In that same year, of 639 medical students who were graduated from five medical schools that provided no exposure to family practice, only 44 (6.9%) entered family practice residencies.

Bright, caring medical students make bright, caring family practice residents and successful family physicians. And nothing will enhance the viability and prestige of the specialty more than making it attractive to it the very best students and providing them with the very best residency training. So certainly academic credibility is important, but it is most important as it relates to meeting the original goals of the founders of family practice residency training—getting the best doctors to the people.

Since the following points would be considered only biased opinion if stated as fact, they will be presented as questions, thus softening the tone, but not the intent. Should the state supported medical university be obligated to respond to the needs of its taxpaying supporters by insuring a strong department to train the type of physicians needed by those taxpayers? Should every medical student be required to rotate through a primary care, more outpatient-oriented specialty? Should family physicians be given a place on admissions committees, curriculum committees, and other important decision-making bodies?

These questions are, of course, no more controversial or argument-provoking than are questions on religion, politics, and college football polls!

Conclusion

Up to now in this review, the emphasis has been on global problems or questions. In conclusion, some specific comments will be offered about family practice education at the University of Florida College of Medicine and Alachua General Hospital. Family Practice is growing and thriving in Gainesville. In the area of curriculum, cooperation from basic science instructors and from other clinical department faculty has never been better. Medical students are receiving valuable educational experiences in family practice centers in metropolitan areas and small cities, in rural clinics, and in the offices of preceptors throughout the state. Residents may elect to rotate through a number of clinical services at Shands Teaching Hospital. Support from the office of the Dean of the College of Medicine is increasing as is support from community physicians and from the administration at Alachua General Hospital. Funding is not what we would desire (is it ever?), but it is stable, partially through the good offices of the Community Hospital Education Council. Cooperation and support from the Florida Academy of Family Physicians could not be stronger.

Family practice at the medical school in general, and at the University of Florida in particular, despite the problems, challenges, and controversies, is here to stay!

References available from the author upon request.

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Factors Affecting Residency Program Dropouts A Longitudinal Study

John J. Dallman, Ph.D., M.D., Lee A. Crandall, Ph.D. and William H. Haas, M.A.L.S.

Introduction

Florida's family medicine residency programs have substantial numbers of residents who drop out after one year. In 1976-77, 21 of 64 (33%) of the first year residents entering civilian family practice programs dropped out. Similarly in 1977-78, 13 of 66 (20%) and in 1978-79 15 of 69 (22%) dropped out. This amount of attrition causes scheduling difficulties, reduces service to patients, and disrupts continuity of care. Serious problems are created for program directors in providing uniform educational experiences and in stabilizing program budgets. Given the multitude of opportunities into which a partially trained resident can go, the task of defining who it is that leaves family practice and who stays to completion of a program can provide useful data for program directors and policy makers.

A project was begun in July, 1977, to study the attrition issue. This study is sponsored jointly by the Department of Community Health and Family Medicine at the University of Florida, the Florida Council on Graduate Education for Family Practice, and the Florida Academy of Family Physicians.

Study Instruments

The instruments employed in this project were designed to gather a large number of items of information on each resident entering family practice residency programs in Florida. The first phase of data collection is accomplished using the "Survey of Entering Residents."

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The first two sections of this questionnaire deal with background information and obligations and plans. The background section is lengthy and covers aspects of personal data, environment, family, finances, interests and hobbies, education and work experiences. Financial security, autonomy, lifestyle, social position in the community and peer group position are examined in the "Career Goal" section of the initial survey. Residents are asked to rank the order of importance of each item as it relates to their career. A section of the questionnaire entitled "Family Practice Residency Content," allows respondents to express their views of the ideal family medicine training program.

The attitude section of this questionnaire identifies concerns of residents which reflect the goals of family practice and delineate family practice from other medical disciplines. Major areas surveyed include: 1) identification with aspects of medicine unique to family medicine; 2) relationship to other health professionals; 3) handling of psychosocial problems; 4) emphasis on ambulatory medicine versus hospital based medicine, and; 5) emphasis on a broad spectrum of medical practice.

The instrument used in the "Follow-up Study," after one year of training includes the same sections on career goals, desired content of family practice residency programs, and attitudes toward family medicine and primary care which were asked in the survey of entering residents. Change over the year can therefore be studied. This questionnaire deletes background information which has already been collected and adds questions dealing with each resident's perceptions of the emphasis actually given to various objectives in the residency program. Also added are questions dealing with the resident's future plans and overall satisfaction with the year's experience. Residents leaving family practice are asked to provide reasons for this decision.

Findings

The research reported here is based on two complete cohorts of family practice residents, those entering in July, 1977 and those entering in July 1978. Findings are based on 98 of the 110 respondents (89%) who completed both the initial and follow-up surveys.

The data from the two years have been pooled since virtually no differences were seen when comparing responses from 1977-78 and 1978-79. It is of interest to note that the response rate for the entering survey was 72.6% overall, 83.2% for the nondropouts and 32.1% for the dropouts.

The low survey response rate of the dropouts must be considered when interpreting these data. Since only a third of those residents who drop out are represented by these results one must be careful when drawing inferences about the entire group. Nevertheless, several interesting differences exist among respondents who dropped out and those who continued in family practice residency.

Background Characteristics

Factors in the demographic category which showed no differences between dropouts and nondropouts included sex, marital status, age, number of children, race, citizenship, hometown size and location.

A statistically significant difference was found in the sources of financial support which residents reported. More of the individuals who dropped out depended on both themselves and their spouses for financial support than was the case for nondropouts who were more likely to depend only on their own earnings. The amount of indebtedness reported was similar for both groups. Individuals who had attended private and/or three year medical schools also appeared slightly more likely to become dropouts.

When asked which rotations in medical school they preferred, residents later identified as dropouts preferred emergency medicine and psychiatry by a factor of 10 to one over their colleagues who didn't drop out. Preferences of those who didn't drop out were spread out over obstetrics, medicine, pediatrics, and surgery, with a smattering of interest in many other disciplines. Class rank, satisfaction with medical school, and work experiences showed no apparent differences.

Goals, Activities, and Attitudes

The residents were asked to rank two pairs of six statements on career goals both on the entering and follow-up surveys. Comparison of the rankings between dropouts and nondropouts showed statistically significant differences at $p < .05$ in the following areas:

1. Dropouts ranked economic motives higher than nondropouts. That is, they ranked the items on providing capital for investment higher than their peers who didn't drop out. This opinion persisted on the follow-up survey also.
2. Having time for family and leisure activities also was ranked higher by dropouts than nondropouts. This opinion was reinforced by the dropouts opinion on an attitude question which stated that "Family Medicine leaves little leisure time for family life or recreation." Dropouts agreed more strongly with this statement than the nondropouts, suggesting that fear of overwork may have encouraged these residents to seek another specialty.
3. Gaining the trust and confidence of their patients was more important to nondropouts than dropouts on the entering survey and was again statistically significant at $p < .05$ on the follow-up survey.

The rank order of the career goals for both dropouts and nondropouts for the entering and follow-up surveys is shown in Table 1. Note the persistent ranking pattern for each group. Those who continued in family medicine placed a higher value on patient and peer relationships while lifestyle and financial security were more important to those who dropped out.

The activities section of the questionnaires produced some isolated but interesting results. This section asked residents to rank six activities of a family practice program in order of preference. These were to be ranked on the entering survey in a prospective manner and in the follow-up survey in a retrospective manner. No differences between the two groups occurred on the entering survey. However, on the follow-up survey, working with consultants was ranked statistically significantly lower for the dropouts than for the nondropouts.

The emphasis placed by a residency program on 12 various aspects of family practice training such as reinforcing clinical knowledge of disease, working with consultants and doing clinical research were also assessed by each resident. Interestingly, dropouts were more likely than nondropouts to state that their programs had too little emphasis on getting to know their patients. The dropouts also felt that their programs had too little emphasis on developing interpersonal skills. Perhaps these seemingly contradictory findings are indicative of a different personality type in dropouts.

The attitude sections of both the entering and follow-up surveys showed a significant difference in the residents' attitudes toward preventive medicine. Nondropouts were significantly more interested in health maintenance than dropouts, i.e., dropouts thought "curative" medicine more interesting than "preventive" medicine.

Table 1. Rank ordering of career goals by dropouts and nondropouts on two surveys.

	Rank of Career Goal			
	Dropout		Nondropout	
Career Goal	Entering Survey	Follow-up	Entering Survey	Follow-up
Relationship with patients	1	1	2	2
Freedom of lifestyle	2	2	1	1
Becoming a community leader	3	3	3	3
Gaining respect of other MDs	4	4	5	5
Attaining financial security	5	5	4	4
Contributing to research	6	6	6	6

Summary

This project has generated much data some of which is illustrative of the differences between dropouts and nondropouts in family medicine residency programs. Given the comments noted earlier regarding differential response rates, it appears that dropouts may differ from nondropouts in several respects. Those who continue in family practice appear to place more emphasis on their patients and colleagues while dropouts are more concerned about their incomes and lifestyles. Dropouts perceive family practice as allowing less free time and are more interested in curative medicine than are the residents who continue in family practice.

As this study continues and more data are gathered, the pattern which emerges will hopefully allow residency program directors to assess their residents more accurately and to be aware of characteristics which may identify potential dropouts.

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Fifty Years Ago

In *The Journal of the Florida Medical Association* for September 1930:

An advertisement pleaded with physicians to specify "Knox Gelatine" rather than the generic "gelatine" in prescribing for diabetic diets . . . The scientific section included papers on "Perforation of the Caecum by a Tooth Pick—Case Report" by **T. H. Wallis, M.D.**, of Ocala, and "Some Duties of the Obstetrician" by **H. Quillian Jones, M.D.**, of Fort Myers . . . At its convention in Detroit, the American Medical Editors and Authors Association called for creation of a "Portfolio of Public Health" in the President's Cabinet . . . The U.S. Civil Service Commission announced an examination for positions as Senior Medical Officer (Pathology) with a salary range of $4,600 to $5,400 per year . . . **J. C. Pate, M.D.**, of Tampa, recently completed six weeks of visiting surgical clinics in the North and East . . . **A. T. Eide, M.D.**, is organizing an American Legion post at Lake Placid . . . **W. H. Y. Smith, M.D.**, formerly of Tampa, was named health officer of Taylor County, the first county-wide organization to be approved under the 1930 program . . .

And so it was in Florida medicine 50 years ago this month.—E.D.H.

A Hospital Administrator Looks at Family Practice

Sister Catherine Norton

One of the significant developments at St. Vincent's Medical Center during the decade just concluded was the establishment and growth of a three-year family practice residency program. After considerable study and planning, the program was opened in 1972 and by June 1980 had served as the training ground for more than 40 young physicians.

St. Vincent's wholeheartedly endorsed the esablishment in 1969 of Family Practice as the 20th specialty of medicine in recognition of the important role a physician dedicated to the continuing care of entire families could play in our hospital and our community. In the intervening 11 years, we have seen our expectations more than fulfilled as family practitioners have become a valuable adjunct to our mission of delivering quality patient care to our community and surrounding area; moreover, the growth and success of our family practice residency program has enabled St. Vincent's to provide valuable new services to our patients and to make available certain low-cost health services to underprivileged members of our community which would not have otherwise been possible. Finally, the appearance and growth in number of family practice physicians is solving a need for more primary care doctors in our community and, particularly, the suburban and rural areas which surround it. All these factors we see as improving the quality of health services and, as a result, the quality of life in Northeast Florida. I shall now look at the aforementioned benefits in some detail.

The presence of the family practitioner as an integral member of the medical staff lends significant support to the philosophy and objectives of a Christian hospital. The residency program plays an important part in the preparation of aspiring family physicians for their expanded role of care for the whole person. Beyond the excellent education provided by the program faculty and the valuable ability to monitor and foster the ongoing health management of families through the Family Practice Center, residents benefit from their day-to day exposure to social and spiritual resources within the hospital. For example, our residents have become a major source of referrals to our Home Care and Social Services programs and work closely with our Pastoral Care Department to ensure that their patient's and their family's social and spiritual needs are served, both while in the hospital and after discharge. At St. Vincent's, our philosophy stresses care for the whole person and as such we attempt to instill these ethical values into the ongoing development of the physician. In a sense, the physician may be seen as a mediator between the patient, his family and "forces of nature"; he presides over these forces and helps to coordinate their several activities. Because the physician is concerned with the whole patient, the spiritual dimension is not overlooked. By assisting in healing mind and body, the physician helps the patient to regain or retain physical and mental health, and so more freely to respond fully to God's grace. Thus the caring philosophy of the Christian hospital is fostered by the resident.

Personal involvement with these particular hospital services has led to several residents becoming keenly interested in such specific concepts and services as hospice, death and dying, and geriatrics. It is noteworthy that our family practice program has received a major grant to provide funding for development of a division of geriatric medicine and gerontology within the residency program. Moreover, residents' continuing interest in the non-physical needs of their patients has been an integral force in the addition of a behavioral scientist to the full-time family practice faculty.

Another major impact brought about by the introduction of family physicians into the hospital environment and the community has been a marked increase in referrals to other medical specialists and to secondary and tertiary care services within our medical center. In joining internists and pediatricians as providers of primary care to their patients, family doctors occupy a unique position in determining which speciality services, diagnostic modalities, surgical procedures and/or therapeutic activities will be beneficial. Staff radiologists, cardiologists, cardiovascular surgeons, and pulmonary specialists, as well as a variety of diagnostic specialists who maintain their practice outside the hospital, receive a considerable number of family practice referrals, including many from residents.

The benefits from this relationship are, of course, mutual. The specialist gains the referral, the family doctor develops the necessary expertise to provide optimal care for his patient, and the resident becomes familiar with the many resources available through the medical center. Appropriate referrals strengthen the institution and

The Author

SISTER CATHERINE NORTON

Sister Catherine recently completed an assignment as President, St. Vincent's Medical Center, Jacksonville.

enhance the efficient utilization of hospital-based services.

A related advantage accruing to the hospital as a consequence of the family practice residents' presence results from their student-mentor relationship with the attending staff. Studies have shown that the residents' continuing quest for medical knowledge and their natural drive to profit from the experiences of their seniors provides a stimulus to the active physicians who quite naturally do not wish to be caught short for an authoritative answer. As the attending staff is induced to keep on its toes, the care delivered to our patients is commensurately enhanced.

The hospital and residents serve each other well during their three-year relationship. The residents learn of and become comfortable in using the hospital's many services and in professional interaction with nurses, allied medical professionals, and other employees. In return, the residents enable the hospital to extend services to segments of the community which might not otherwise receive them. For instance, St. Vincent's family practice residents rotate through our obstetrics clinic, where they manage low-income maternity patients throughout their pregnancy. By virtue of their background and training, the resident enhances and supports the Medical Center's family centered approach to maternity care. Through their services, the hospital is able to provide service at low cost to patients who otherwise could not afford care in a private hospital.

By virtue of their recent medical training, residents are knowledgeable and generally supportive of various modern-day health promotion programs which are rapidly assuming a major role in hospital marketing activities. Community health education programs, wellness activities, and outreach services such as health screenings and lifestyle modification classes are among the areas in which family practice residents serve the hospital and help improve its image within the community.

But perhaps the greatest impact the advent and development of the family physician has had on the hospital and the community is the provision of qualified medical care in areas lacking enough physicians. While our community has had a sufficient number of well qualified physicians over the years, rapidly growing suburban developments and outlying rural areas in Northeast Florida need more primary care physicians. Furthermore, we are seeing an increasing need for physicians to serve the inner city. With the majority of medical school graduates still opting for more narrowly based segments of medicine, the introduction of new family doctors into medically underserved areas takes on paramount importance.

The family practice residency program is proving to be a blessing as many of our graduates are choosing to set up practice in Northeast Florida, a considerable number of them in areas with physician shortages. As an added benefit, our graduates, who have spent three years learning the policies and modus operendi of our hospital and building relationships with the physician and employee staff, are choosing to continue their support of the institution, seeking privileges to practice here and referring their patients here for specilty care.

By all accounts then, the growth of the specialty of family practice and the opportunity to provide physician education through the family practice residency program has proved an unqualified benefit to St. Vincent's Medical Center. I suspect that my hospital colleagues, particularly those fortunate enough to have a family practice residency program operating within their institution, would wholeheartedly agree with my assessment.

• Sister Catherine, 1800 Barrs Street, Jacksonville 32204.

A Legislator Looks at Family Practice

Mr. William R. Conway

About 10 years ago I attended the Smith, Kline and French Laboratories' conference held at Walt Disney World to explore the needs and means to achieve an adequate number and distribution of family practice doctors. I was so impressed with the discussions concerning the need for, and advantages of, family practice physicians to the citizens of Florida. I was determined to help secure necessary funding to assist in the development of an educational program in family practice in the state.

Governor Askew was very supportive of additional funding and legislation to implement the training program. After the second year of operation the Governor volunteered to include in his annual budget the necessary funding requirements to continue the program.

The trend toward a high percentage of specialists in the medical field added greatly to the cost of medical care and did not appear to be in the best interest of the general public. I felt that a change in direction was needed and a return to educating family physicians was one answer to the problem of health care delivery.

At the time, the number of family physicians in Florida was decreasing and few medical students were interested in specializing in family practice because of many unfavorable circumstances. It took a concentrated effort on the part of a few loyal doctors and legislators to attract more qualified and dedicated students to family practice training programs.

In my legislative district, Dr. Richard Dodd, Director of the Family Practice Residency Program at Halifax Hospital Medical Center in Daytona Beach, has done an outstanding job in organizing and implementing an educational program for training family physicians. His dedication and sound arguments in favor of continuing this program have impressed many of us and encouraged the legislature to continue funding residency programs.

Education for family practice is based on need and is now receiving the attention and support of the leadership and the citizens of the State of Florida.

I am glad to have been in on the early discussions and to be invited to support the objectives of family practice through legislative means. I feel that substantial progress has been made toward these objectives to bring back the family physician to serve the people of Florida. I am happy to have had a part in this progress.

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Government Support for Family Practice Education

Kenneth E. Penrod, Ph.D.

The term "support" has many nuances but the one generally associated with government is financial assistance. This will be the theme of this paper although another important form of government support in the recent past — persuasion to establish departments of family practice in some reluctant medical schools — should not be forgotten.

State and local governments have a long history of involvement with medical education. Some of the earliest medical schools and teaching hospitals were dependent upon local taxation and today well over half of the 126 medical schools in the U.S. are "public owned."

The federal government, on the other hand, is a relative newcomer to medical education financing. It is not fortuitous that the rapid growth of federal interest parallels the development of the specialty of family practice throughout the country. A large portion of the federal subsidy has been targeted to this maturation.

Career goals may be formulated while in medical school but it is in the graduate training period that specialty preparation takes place. The family practice residency is less self-supporting than most other graduate programs and is therefore in need of government aid, as will be brought out.

What Does Graduate Medical Education Cost?

Cost accounting is an arcane science for most of us, but this should not obscure some broad approximations. Family practice residents in Florida average approximately $15,000 each per annum in stipend and benefits. Paid teaching faculties vary from program to program but average close to another $15,000 per resident. Staffing and operating the necessary Family Practice Center costs at least $10,000 per resident, making the annual outlay approximately $40,000. This gross cost will vary from place to place and takes no account of hospital expenses of providing some inpatient facilities as well as laboratory and x-ray.

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How does this cost compare with that of a resident in another specialty? In the teaching community hospitals in Florida it may not be very different. We do not have good data on this. But Tarlov and associates have published recent national data on the cost of internal medicine residencies. Their resident stipends and benefits are slightly higher. However, since three-fourths of the hospitals in their study are medical school owned, or major affiliates, the mixed duties of the teaching faculty cannot be readily separated. There is no mention of cost to hospitals to provide the teaching facilities.

It is generally conceded there are additional costs associated with a residency program. These vary among the departments and services of the hospital. Martz and Ptakowski found such costs to add about 20 percent to the average total patient bill. However, this was for the hospital bill only without mention of possible offset in professional fees.

Until the family practice residency was designed a decade ago, specialty training differed somewhat in content but little in format. All centered upon the hospitalized patient, and the house officer provided long hours of service to patients on behalf of the institution. Costs to the hospital were generally fully recoverable through patient bills or other sources of income but the shift to ambulatory patient focus of family practice, while salubrious from many philosophical angles, has created formidable problems of underwriting. The income from outpatients does not begin to match that from inpatients and, to compound the problem, insurance programs are strongly biased in favor of hospitalization.

Who Should Pay for Graduate Medical Education?

The logical answer to this question is: its beneficiaries. Who are they? Certainly the patient being cared for is one, but a cogent argument can be made that all of society benefits by the presence of a cadre of well trained physicians. The method our society has adopted for meeting shared debts is payment through taxes.

For years the argument has been advanced that the cost of Graduate Medical Education (GME) should not be borne solely by the patients. This may have once been the case but it certainly is not so today. The overwhelming proportion of hospital costs, including

housestaff, are paid not alone by the patients but by a broad spectrum of the public. In part they do so through local government tax (e.g., tax district hospitals) and in part by a private tax (health insurance).

Since the federal government has significantly increased the demand for physician manpower through its many social programs it can be said to have obligated itself to aid in the support of GME. The federal government is indeed supplying a significant proportion of the total GME support in a variety of ways. Nearly one in five residency positions in the U.S. is federally sponsored by VA, DOD or PHS. The Department of Health, Education and Welfare awards grants in support of residency programs in family practice, general internal medicine, general pediatrics, and emergency medicine. In addition, responsibility is acknowledged in the Provider Reimbursement Manual for Medicare (405.421(c)) which states:

> "Many providers engage in educational activities including training programs for nurses, medical students, interns and residents, and various paramedical specialties. These programs contribute to the quality of patient care within an institution and are necessary to meet the community's needs for medical and paramedical personnel . . . Until communities undertake to bear these costs, the program will participate appropriately in the support of these activities."

It has been estimated that the federal government, through this Medicare-Medicaid participation, now pays about 35 percent of resident salaries and fringe benefits in non federal hospitals.

Although, as noted, a major share of the payment for patient services provided by residents is from money collected from a cross-section of society (tax and insurance premiums) there are still concerns for how much of GME is service and how much education. In one sense, efforts to separate service and education time of house officers are meaningless. On the other hand, pressure is mounting on the health care system to head off rising costs. One way to do this is to eliminate all costs that are not directly a part of patient care.

The arguments favoring a separation in accounting are gradually winning out, but achieving this is not easy. In an effort to separate service and education by time allocation, the Institute of Medicine logged the activity of house officers at 96 teaching hospitals. The study was confined to medical school owned and major affiliated hospitals only. They found 62 percent of the time was in activities related to patient care, with the remainder devoted to teaching other house officers and medical students, and self-learning. These percentages tend to fit the pattern of financial support in many places. In the previously mentioned study of Tarlov et al the proportion of house officer support from the sponsoring hospital funds averaged 68.4 percent.

While much of the family practice resident's time is spent in the outpatient care center, the amount of inpatient service rendered during the rotations on other services in the three years is appreciable. Nonetheless, with relatively poor income from the clinic services, many hospitals report they are hard pressed to cover more than about one-third of the costs of sponsoring a residency program.

Both federal and state legislators have been made aware of this fact. The federal government provides direct aid to some family practice (and to a lesser extent other primary care) residency programs, mainly for start-up and expansion. Many states now give long term assistance to their family practice residency programs. State assistance varies widely, from as high as approximately three-fourths of the cost of some programs to no assistance by a few states. The current grant-in-aid to family practice residencies in Florida averages $11,826 per resident.

It is apparent that government in its many forms is heavily involved in providing the resources necessary to prepare physicians for family practice careers. This support is provided in a variety of ways, indirectly through aid in payment for patient services and directly in the form of grants for aid to education. The specialty of family practice appears to be uniquely in need of governmental assistance if its training programs are to continue to focus on ambulatory, lower cost medicine. Such support would appear to be a shared responsibility of local, state, and national governments.

References available from the author upon request.

● Dr. Penrod, 107 West Gaines Street, Tallahassee 32304.

The Patient Sets the Limits

Harry W. Barrick Jr., M.D.

Each day practicing family physicians make many decisions regarding patient health needs. We use experience gained from years of medical education and from many years of practice to form treatment programs designed for the best results for patients. In spite of years of education and practice we can fail if the plan we submit to the patient is unacceptable to him. If he is unwilling to diet, unwilling to exercise, unwilling to stop smoking, or if he will not follow his prescribed regimen, our efforts in his behalf may have been in vain. No matter how wise the advice given by his doctor, no advantage my accrue to the patient.

Each time we advise a patient, we must be aware that the patient himself sets the limits on our treatment plan. Patients decide how much of the plan they will follow. If the physician's plans exceed the patient's willingness to follow those plans, both physician and patient can experience frustration.

A patient is noncompliant when he is unwilling or unable to follow the physician's direction. We have asked him to make changes in his life. He makes a judgment as to whether those changes are worth the time, effort, or money required to comply with the physician's plans. When the patient decides that all or part of the treatment plan is not worth the time, effort, or money it would cost, he becomes noncompliant. Then we see obese patients who say that they can't lose weight, diabetics who are out of control, hypertensives who take their medications irregularly or who run out of medicine before the next scheduled office visit and many other patients who do not follow instructions.

Did the patient fail us or did we fail to perceive the limits of treatment he would be willing or able to follow?

Each of us has wanted to say: "If he won't do as I tell him, he needn't come back." Does this approach treat the patient or the physician? Is our goal to help the patient or to seek self gratification? It seems quite obvious that if we have no contact with the patient we shall be unable to help him. In such a case, the physician's knowledge and skills are useless to the patient. If, however, the patient will follow 10% of our advice this time, he may benefit some, and if we are skillful and establish good rapport with the patient, we can eventually (and it may take years) get the patient to accept more and more of our proposed treatment plans.

It is imperative that physicians recognize limitations placed on treatment by patients. By working within the limits the patient sets, we can achieve varying amounts of success. These limits vary widely. They relate to the patient's circumstances: His family's approach to medical care as a child, his childhood experiences with doctors, his fears and prejudices, his military experience, his wife's ideas and viewpoints, his job, his self image, his cultural setting, his financial status, and his educational background.

An example is represented by the patient who will allow treatment only during serious life-threatening crises. The other extreme is the patient who turns to you for advice on every imaginable matter and follows your instructions compulsively. Most patients fall between these extremes, and the successful physician will determine the limits and use them to the patient's advantage.

Does this approach mean that the physician lowers his standards? Absolutely not! Our treatment goals are still the same, but we realize that we may achieve only part of the goals now and others later. Little progress is better than none at all. So, in succeeding visits and through the years you should be able to enhance patient compliance through repeated contacts, through education, and through the growing trust and confidence of the patient. When the physician practices in this way, he will not fail because he had each time met the patient's needs as determined by the patient who is the only one who can make that determination.

Family physicians see the advantages and strengths derived from continuity of care. We know the advantages and strengths of longterm management and association in all health problems. The results are best when the patient and his physician work closely together.

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Recurrent Pulmonary Disease as the Presenting Problem in Cases of Gastroesophageal Reflux in Infants and Children

Mary P. Kellogg, M.D. and Nicolas Allende, M.D.

Abstract: Twenty-one successive cases of gastroesophageal reflux in infants and children were reviewed from hospital charts at St. Vincent's Medical Center, Jacksonville, Florida, from July 1976 to February 1980. Sixteen of the 21 children had barium esophagrams that demonstrated reflux and 15 of these had respiratory problems presenting as the main complaint. A variety of respiratory problems was found in this group. We found recurrent pneumonia, apneic episodes, and near-respiratory arrests. Mechanisms explaining how gastroesophageal reflux produces respiratory problems were discussed. Gastroesophageal reflux should be considered in the diagnostic evaluation of all infants and children who present with unexplained recurrent or persistent respiratory complaints.

Introduction

Gastroesophageal reflux has long been recognized as producing a variety of symptoms in infants and children. It has been associated with failure to thrive, gastrointestinal bleeding, and esophageal stricture. Pulmonary manifestations of reflux have been reported along with the gastrointestinal symptoms. It is our impression that gastroesophageal reflux is a major cause of recurrent respiratory complaints, second only to asthma and recurrent upper respiratory conditions.

Gastroesophageal reflux has been proposed as an underlying cause of recurrent pneumonia and bronchitis, choking, apnea, cyanotic spells, and even respiratory arrest. When recurrent or persistent pulmonary disease is found in association with gastroesophageal reflux and in the absence of other causes, reflux is probably the cause.

In this study we will review cases of gastroesophageal reflux and recurrent pulmonary disease as they present together in infants and children. Some mechanisms that have been proposed to explain their clinical association will be discussed.

The Authors

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Materials and Methods

Hospital charts bearing the diagnosis "Gastroesophageal Reflux" were selectively studied from admissions to St. Vincent's Medical Center, Jacksonville, Fla., from July 1976 to February 1980. Children one day to 19 months old were selected, and only those in whom reflux was radiographically demonstrated were used in the study. The patients studied were all admitted by primary care physicians, both private practitioners and family practice residents.

Results

Sixteen of the 21 cases that bore the diagnosis "Gastroesopageal Reflux" had positive barium esophagrams. The barium esophagram was used to confirm the diagnosis of gastroesophageal reflux because it is the only readily available laboratory test for reflux in our hospital. It must be borne in mind that the barium esophagram may not always demonstrate reflux.

Table 1 summarizes our clinical data. We found that 15 of the 16 children presented with respiratory complaints. Three had episodes of recurrent apnea and cyanosis, and two of these had documented near- respiratory arrest. Four patients presented with recurrent pneumonia, two with aspiration pneumonia, and one with frequent upper respiratory congestion and cough along with one documented occurrence of right middle lobe pneumonia. Two children presented with cough and one of these had cough and choking at night. Two others had recurrent wheezing and were diagnosed as having asthma.

Three of the 15 children with respiratory com-

plaints underwent surgical correction of the gastroesophageal reflux. One of these patients had four episodes of recurrent pneumonia from the age of six months to three and one half years, at which time surgery was done. He had no subsequent episodes of pneumonia. The other patient who required surgery had been hospitalized four times with recurrent pneumonia, bronchiolitis, and documented apneic episodes from age two weeks to six months. He had no further pulmonary problems during two years of follow-up observation. Another child had apnea and cyanotic spells which resolved completely following surgery.

The remainder of the cases were treated medically for various lengths of time and with regimens based on upright posturing and frequent thickened small feedings. Most of these patients were found to improve with treatment during hospitalization. The follow-up period has varied from three months to almost three years. For most patients, no further hospitalization for recurrent pulmonary disease was required after therapy was instituted.

Table 1. — Clinical Data on Cases Reviewed with Radiologically Demonstrable Gastroesophageal Reflux

Case	Age	Sex	Respiratory Complaints*	Other Clinical Features
J.F.	13 mo.	F	None	Failure to thrive, vomiting, hypochromic anemia
M.S.	3 mo.	F	Coughing, choking at night	Rumination, irritability, vomiting
J.V.	1 mo.	M	Cough, chest congestion, wheezing (asthma)	Vomiting,
V.R.	13 wks.	F	Cough, rhonchi (aspiration pneumonia)	Vomiting (failure to thrive)
D.F.	1½ mo.	M	Cough	Vomiting
A.B.	1 day	F	Cyanosis, apnea, stridor near-respiratory arrest	
J.K.	3 mo.	M	Repeated upper respiratory infectious wheezing (asthma)	
S.D.	1 mo.	F	Cough (pneumonia x 2)	Vomiting
M.S.	2 wks.	M	Cough, tachypnea, wheezing, (recurrent pneumonia), apnea, (bronchiolitis), choking	Vomiting
K.N.	10 wks.	F	Cough, chest congestion, (bilateral bronchopneumonia)	Vomiting
G.M.	12 days	M	Choking, cyanosis, apnea, near-respiratory arrest	Vomiting
C.B.	8 days	F	Apnea, tachypnea, labored respiration	Vomiting
K.	19 mo.	F	Frequent upper respiratory infections, right middle lobe pneumonia	Vomiting
J.H.	6 mo.	M	(Recurrent pneumonia x 4)	Vomiting
K.B.	2 mo.	M	Rhonchi, wheezes (bronchitis) mucoid rhinorrhea, tachypnea	Vomiting
C.K.	12 mo.	F	Frequent colds, congestion, cough, (aspiration pneumonia)	

*Terms in parentheses are clinical diagnoses, other terms are presenting signs and symptoms.

Discussion

Several mechanisms have been proposed to explain the pulmonary manifestations of reflux. McCauley, et. al. demonstrated radiographically aspiration of refluxed barium outlining the trachea and bronchial tree. Other investigations have reported autopsy proven cases of extensive aspiration into the tracheobronchial tree. This type of aspiration, if it is massive, obstructs the air passages and can quickly lead to respiratory arrest. Lesser degrees of aspiration can account for lobar pneumonias.

Laryngospasm in the absence of gross aspiration has been investigated. Experimental studies in piglets have shown that apnea can be produced by introducing liquid into the trachea. The apnea can be prevented by section of the superior laryngeal nerve or reproduced by stimulation of the nerve.

Other authors have proposed a reflex mechanism to explain the association between gastroesophageal reflux and asthma. It has been postulated that esophageal receptors can trigger a reflex through the vagus nerve causing bronchoconstriction. The authors state that their findings were demonstrated with patients in an upright position making undetected aspiration unlikely.

Regardless of the mechanism, the experience of many clinical investigators has reinforced the correlation between reflux and chronic or recurrent respiratory disease. One clinical study of fifteen patients with recurrent acute respiratory symptoms and who were evaluated for gastroesophageal reflux showed good correlation between the barium esophagram, measurement of lower esophageal sphincter pressures, and acid reflux testing. Five of these patients required surgery which resulted in resolution of the respiratory symptoms. Eight of them treated with medical therapy were followed for at least three months with no further recurrences of respiratory symptoms.

In a prospective study, Euler et. al. performed four different esophageal function tests including esophagram, esophageal manometry, pH probe test, and eso-

phagoscopy with biopsy on 30 children referred for either chronic asthma or two or more documented pneumonias within a one year period. Nineteen of the 30, or 63% of the patients, had gastroesophageal reflux based on two or more positive tests.

A larger study by Danus et. al. included 43 children with recurrent obstructive bronchitis but without prominent gastrointestinal symptoms. Radiographic evidence for reflex was demonstrated in 26, and in 15 of the 20 children, alleviation of the pulmonary symptoms occurred with medical anti-reflux treatment. A series of 18 infants and children were referred to David and Fiuzat because of recurrent bronchitis, bronchiolitis, and pneumonitis. Nine of these received anti-reflux operations. One was considered a treatment failure, and the others demonstrated marked improvement of the respiratory symptoms even though some follow-up esophagrams showed persistence of reflux.

Recurrent nocturnal asthma has been correlated with the presence of gastroesophageal reflux in children who go to bed after eating a large dinner or after ingesting large amounts of liquids. A medical anti-reflux program was effective in eliminating nocturnal asthma attacks in this series of patients who had radiologically demonstrable reflux.

Gastroesophageal reflux has also been proposed as a possible cause of the suddent infant death syndrome. The authors suggest surgical fundoplication for all patients who have respiratory arrests secondary to gastroesophageal reflux. Another study cited 14 infants with cyanotic and apneic spells and severe gastroesophageal reflux documented with barium esophagram, esophageal motility, and pH measurements. In this series nine of the infants responded to medical therapy and five underwent surgical correction of reflux because of recurrent life threatening episodes that did not respond to medical therapy.

A useful clinical evaluation and classification of patients with pulmonary symptoms and gastroesophageal reflux has been devised by Darling et. al. In their classification Group 1 pulmonary disease almost certainly caused by G.E. reflux includes pulmonary disease controlled only by surgery or ultrastrict medical therapy, i.e., nasogastric sùctioning, and total parenteral alimentation. Also found in Group 1 are cases of autopsy-proved massive aspiration, or radiographically demonstrated aspiration of refluxing barium. In their Group 2, pulmonary disease probably caused by G.E. reflux, they include pulmonary disease that responded to routine medical therapy for reflux. Group 3, pulmonary disease possibly caused by G.E. reflux, contains those cases that show a protracted shifting pattern of pulmonary involvement in patients who must remain supine and in whom no other cause has been found and those in whom aspiration of contrast material is seen during swallowing. Group 4 contains patients with pulmonary disease probably unrelated to G.E. reflux. These diseases include pulmonary disease that responds promptly to appropriate specific therapy, transitory or protracted respiratory conditions without identifiable cause and not helped by anti-reflux therapy, and pulmonary diseases of known etiology such as congenital heart disease with congestive heart failure and bronchopulmonary dysplasia. Such a classification is useful for the community hospital-based physician since it employs the esophagram and clinical observations and not the other tests such as manometry and pH measurements.

Summary

We have reviewed 16 selected pediatric charts bearing the diagnosis "Gastroesophageal Reflux" and found that 15 of the cases so diagnosed presented chiefly with respiratory symptoms. We have found that many kinds of respiratory problems can be associated with gastroesophageal reflux. These problems range from recurrent cough to severe problems such as choking, apnea, and respiratory arrest. We have found esophageal fluoroscopy to be a useful test in confirming a clinical suspicion of gastroesophageal reflux in infants and children. We bear in mind that clinically significant reflux may be present even though we have a negative esophagram.

We believe that gastroesophageal reflux should be considered in the diagnostic evaluation of infants or children with unexplained recurrent or persistent respiratory symptoms in the absence of other known causes, and we add that even a family history of asthma does not preclude the diagnosis of G.E. reflux since reflux can trigger the wheezing. We recommend a trial of medical treatment for gastroesophageal reflux. Posturing at an angle of 60° and thickened feedings constitute the basics of medical management. In the most severe cases surgery is required.

References are available from the author upon request.

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Exercise Testing in Family Practice

A. L. Eberly Jr., M.D.

During the past 24 months I have tested 140 patients. My family practice is on the southeast coast of Florida, where retirees and the elderly predominate.

As far as interpretation of exercise electrocardiograms (EKGs) is concerned, I believe anyone conversant with routine EKG interpretation can, with minimum familiarization, readily interpret EKG stress tests. Exercise EKGs have become increasingly popular since the advent of the computer technology necessary to allow readable EKGs to be done on an exercising patient. It is recommended that the novice avail himself of one or more of the Continuing Medical Education (CME) courses on Stress Testing.

The main reasons for stress testing are:

1) To diagnose Coronary Artery Disease (CAD).
2) To follow progress of patients with known CAD. The patients may or may not have had coronary artery bypass surgery.

Four categories of information are available from stress testing:

1) Left ventricular function as measured by blood pressure response while exercising. A deficient blood pressure response indicates poor left ventricular function (less than 20 millimeters rise in systolic pressure).
2) Abnormal rise in blood pressure response indicates labile hypertension. Normal blood pressure rise with a sudden fall is typical of aortic stenosis and is indication to discontinue the test.
3) Development of arrhythmias.
4) General physical fitness (the least important parameter in the older age group).

Siegel reports a good correlation between the percentage of positive results and the number of coronary arteries with more than 70 percent obstruction. Single artery disease is associated with an abnormal EKG response in 60 to 70 percent of those tested, while those with two major arteries obstructed have a positive response in 80 to 90 percent. In those with three or more major vessels, or if the left main is obstructed, then 90 percent of the time there will be a positive test.

The Author

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Symptoms Requiring EKG Stress Tests

The literature reveals which clinical symptoms require diagnostic stress testing. Chest pain and fatigue are common symptoms.

A study done a few years ago in Baltimore found that 30 to 40 percent of people with myocardial infarction complained of fatigue for weeks or months prior to their attacks. It is estimated that about one third of all infarcts are silent, thus if one of your patients in the coronary age group, 40 and above, complains of fatigue without apparent cause he should be tested to possibly head off an attack.

Other generally accepted indications for stress testing include those patients at high risk, i.e., coronary age group, high cholesterol or elevated lipids, smokers, and those with a strong family history of heart disease or sudden death.

Also any person in the coronary age group who has been previously sedentary or relatively inactive physically and then who decides to embark on a strenuous exercise program, either jogging, tennis, or weights, etc., should have an exercise EKG prior to participation in such exercise.

Chung in his excellent text book on stress testing, lists assessment of the nature of cardiac arrhythmias in relation to exercise, and early detection of labile hypertension as additional indications for stress testing.

Prognosis and Evaluation

Another frequent indication for stress testing is for prognosis and evaluation of post myocardial infarction (MI) and surgical bypass patients. Some centers are testing post MI patients 14 to 21 days after the event. Post hospitalization recommendations regarding activities and exercise are based on these results. Stress testing post MI also has prognostic value. Studies show that patients with positive tests in the period shortly after infarction (two to four weeks) are at higher risk in the next five years.

These post MI stress tests differ from the usual stress tests by being conducted at lower work loads. Dr. Levitas attempts to get post MI patients to 80 percent

of maximum pulse rate. If no problems are encountered at this level of stress, then in three to four months an attempt is made to approach maximum or symptom limited pulse rate.

Stress testing is useful in evaluating and following surgical bypass patients and those on medical therapy. The object is to achieve a higher pulse rate and metabolic (met) — expenditure, on testing, with less EKG changes and symptoms, when compared with tests done prior to treatment.

Contra-indications for stress testing are:

1) Acute MI
2) Unstable crescendo angina
3) Serious arrhythmias
4) Acute myocarditis, pericarditis, rheumatic fever and SBE
5) Severe aortic stenosis
6) Acute or severe congestive heart failure

Reasons for discontinuing the exercise test:

1) Patient's request for any reason
2) Chest, arm, or neck pain consistent with increasing angina
3) Dyspnea or weakness
4) Abnormal blood pressure response
5) Marked ST segment depression of more than three millimeters
6) CNS symptoms, that is, abnormal gate with stumbling, dysarthria, or any sign of T.C.I.A.

Precautionary equipment and supplies necessary for EKG stress testing include the following: D.C. defibrillator, IV stand and IV fluids, plus airways, and oxygen. Drugs include: Xylocaine, Lanoxin, Epinephrine, Calcium chloride, Sodium bicarbonate, Solucortef or similar steroid.

After testing, patients should be advised to avoid heavy meals and hot or cold showers/baths. This will avoid vasovagal reactions and unnecessary pooling of blood in skin or splanchnic beds.

Complications of Stress Testing

Complications can be divided into two categories, cardiovascular and musculoskeletal.

Table 1	Number	Percent
Total patients tested	140	100%
Patients with positive stress tests	53	37%
Total patients with known or suspected CAD/angina/MI	105	100%
Positive stress tests	53	50%

Cardiovascular complications are:

1) Sudden death—usually from ventricular tachycardia or fibrillation. The incidence of ventricular fibrillation or tachycardia was one in 5,000 cases in Bruce's study. There were only two deaths in more than 12,000 stress tests done at Cleveland Clinic.
2) Myocardial infarction without death.
3) Angina
4) CHF
5) Hypertension
6) Hypotension with or without shock
7) T.C.I.A., CVA.

Musculo-skeletal complications include fatigue, trauma, peripheral claudication, phlebitis, and retinal separation.

Summary and Conclusions

It is economically feasible and medically advantageous to do stress testing in a family physician's office.

Anyone conversant with EKG interpretation can interpret exercise EKGs after familiarization with the equipment and actual exercise EKGs.

One or more CME courses in Exercise Testing is recommended. Indications for stress testing are discussed. These include diagnosis of CAD, prognosis, and success of medical and surgical treatment.

Complications of and contraindications to stress testing are discussed.

Finally, precautionary emergency medications and equipment are reviewed.

Table 2	Number	Percent
Patients tested without known or suspected CAD	35	100%
Reasons for Testing		
Arrhythmias	11	31%
Non-specific ST-T changes in resting EKG	12	34%
Prior to beginning exercise program	12	34%
Positive tests in above three categories	3	8%

Table 3	Number	Percent
Patients with history of clinical CAD, or documented MI with negative test	20	14%

Results of exercise testing in this office are presented in the following tables.

There were a total of 140 tests accomplished between November 5, 1976 and November 18, 1979. The age range was from 37 to age 81.

References are available from the author upon request.

● Dr. Eberly, 2281 N.E. 36 Street, Pompano Beach 33064.

Twenty-Five Years Ago

In *The Journal of the Florida Medical Association* for September 1955:

The FMA counted four wins and two setbacks in its 1955 legislative program. Victories included hospital service for the indigent, Medical Practice Act amendments, healing arts registration, and real estate tax exemption for county medical societies . . . More than 1,000 residents of the Bowling Green area turned out on July 4, 1955, for an Independence Day program honoring **Wesley S. Pyatt, M.D.**, who had practiced medicine in the community since 1917 . . . **William D. Sugg, M.D.**, returned to Bradenton after presenting a paper at the International College of Surgeons meeting in Geneva, Switzerland . . . The House of Delegates of the American Medical Association expressed "sincere appreciation" to the Florida Medical Association and Dade County Medical Association for hosting the 1954 AMA Clinical Convention in Miami . . .

And so it was in Florida medicine 25 years ago this month.—E.D.H.

Clinical Services for Patients Receiving Anticoagulants

George D. Gammill, M.S., Pharm. D., J. Daniel Robinson, Pharm. D., Charles D. Sands, Pharm. D. Resident and Dennis F. Saver, M.D.

Clinical Service for Anticoagulant Patients

Pharmacists historically have become involved in patient therapy only after diagnosis and treatment regimens have been determined. However, in recent years, great strides have been made to involve pharmacists in actual determination of the most appropriate pharmacologic regimen for many categories of patients.[1]

Greater emphasis on serum drug levels and on pharmacokinetic parameters and more effective utilization of these measurements are but two of the newest changes in medical practice. Additionally, the pharmacist's expertise in compliance assessment has been more fully utilized. Combining these three—compliance assessment, pharmacokinetic determinations, and blood levels—has led to tremendous changes in the role of the pharmacist in therapeutics.

Several reports exist which detail pharmacists' involvement and responsibilities in the management of patients taking anticoagulants.[2,3,4] This paper describes a pharmacy-based anticoagulation service in a university affiliated family practice center. Several examples are presented to illustrate the benefits to patients of such a service.

Development of the Acs

The Anticoagulation Service (ACS) of the Gainesville Family Practice Medical Group (FPMG) was developed to more adequately manage difficult dosage regimens, non-compliant patients, and drug interaction problems associated with warfarin. In addition, the ACS provides education to the patient concerning warfarin.

Since it's inception, patients have been referred to the ACS by resident physicians of the FPMG and have been followed from that point by both the staff of ACS and by the referring physician. All patients who are taking oral anticoagulants are eligible for referral to the ACS. However, because FPMG is part of a teaching residency program of the Department of Community Health and Family Medicine, College of Medicine, University of Florida, it was decided to accept only patients with difficult problems in order that the management of this type of patient not be taken from the experience of the resident.

Physician acceptance and appreciation of our service has been positive. An improvement in patient compliance as measured by prothrombin times (PT) and patient understanding of their therapy has also occurred.

Initiation of a Patient into the Program

The patient is initiated into the ACS program only upon request of the primary care physician. An initial interview with the patient and a review of his therapy is arranged to coincide with the next scheduled laboratory visit. The ACS assumes management of the patient's anticoagulation therapy, with the balance of the patient's medical care remaining the responsibility of the primary care physician.

During the initial visit, the main focus of the ACS is the education of the patient. Drug interactions, particularly with over-the-counter medications and food, are discussed thoroughly with the patient.

The primary goal of the ACS is stabilization of the patient's PT within accepted limits in order to avoid toxicity or inadequate effect. As would be expected, the stabilization period varies from patient to patient. Once stabilized, monthly prothrombin times are done during the out-patient visit. In addition, a hematocrit is done monthly for the first two months and quarterly thereafter.

During each monthly out-patient visit, ACS personnel question the patient about compliance, symptoms of disease, and signs of bleeding. Patient knowledge is once again assessed and reinforced.

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A mechanism exists whereby home visits can be made jointly by the ACS, a social worker, and, on occasion, the nursing staff. Home visits allow the staff to visit the patient in a non-clinical atmosphere and to develop a feeling for the patient's home environment. These visits also serve to identify potential problems and reasons for non-compliance. One patient has been visited at home three times by the ACS in order to reinforce teaching and educational aspects of the program.

As part of the evaluation of patient compliance, pharmacists determine the correct number of tablets, refill dates, and number of refills for each prescription. This information is recorded in the patient's chart. This new service is invaluable to FPMG physicians.

Home visits complement this activity since all medication bottles are available for review and later verification with the dispensing pharmacist. Frequently it is found that patients have several bottles of the same medicine and are taking extra doses.

Dosage Adjustments

Prothrombin time assessments and required dosage adjustments are made by the pharmacist in consultation with the primary care physican. Satisfactory therapeutic management is considered as 1.5 to 2.5 times control PT (e.g., 18-30 seconds, with a control of 12 seconds), unless otherwise directed by the primary care physician.

Effective therapeutic levels with minimal complications can best be achieved in cooperation with patients who are well instructed and who keep the physician and pharmacist informed about their status between visits. Consequently, as clinic visits progress, patient education is provided in increasing depth.

Six patients are presently being followed by the ACS, and their data are summarized in Table I. Each patient presented with a different therapeutic problem, and each required individual attention and discussion concerning anticoagulation therapy.

TABLE I

ACS PATIENT COMPARATIVE DATA

Patient and Demographic Data	Reason for Initiation of Anticoagulation	Reason for Referral to ACS	Daily Dosage of Warfarin	Mean PT (Range)	Other Medications	Problem Identification	Assessment and Plans
S.S. 88 yo BF	Possible Pulmonary Embolus (warfarin begun while in-patient)	Decreasing PT's	7.5 mg	15.8 (11.4-23.6)	Furosemide 80 mg QAM - KCl 20 mEQ BID-Pilocarpine	[1]PT not in therapeutic range [2]Non-compliance	[1]Instruct in compliance when needed [2]Reinforcement of need for Medication [3]Home visits
V.S. 63 yo BF	Embolic Cerebral Vascular Accidents	[1]Hx of complications secondary to warfarin [2]Consistently falling PT's in spite of increasing dose	6 mg	17.8 (14.2-18.4)	Furosemide 80 mg QD - Digoxin 0.25 mg QD - Haloperidol Conc. KCl 20 mEq BID Acetaminophen prn	[1]Non-compliance [2]Dietary interaction	[1]Increase contact with patient via phone [2]To be seen by Upjohn Homemakers
M.O. 79 yo BF	[1]Transient Ischemic Attacks and Cerebral Infarct [2]Surgery considered undesirable which led to warfarin therapy	[1]Need for monitoring [2]Recommendations	6mg 6/19 → 7.5 mg	20.7 (12.9-32.8)	NPH Insulin	Patient taking Indomethacin	[1]Close monitoring necessary [2]Patient Education
O.R. 80 yo BM	[1]Pulmonary Embolus [2]Pulmonary Edema	PT's falling since Sept. 78 (Well controlled from June 78 until Sept. 78)	10mg 6/28 → 5mg 7/18 → 5mg 8/18 → 4mg 9/24 → 5mg	21.1 (13.4-37)	Furosemide 40 mg QD - KCl 20 mEq QD	Falling PT's	[1]Possible non-compliance [2]Possible Dietary interaction [3]Increase dose to 5 mg
B.H. 34 yo WM	[1]Thrombophlebitis [2]Superficial abdominal wall vein thrombosis [3]Pulmonary embolus	[1]Monitoring and follow-up [2]Patient education	10 mg	27.1 (21.5-30.9)	Quinamm[R] 1 HS Vicon-C 1 QD	Possible Drug interactions (5/1 to 5/10) (6/26 to 7/5)	[1]Increase patient Contact [2]Patient Monitoring
M.S. 62 yo WF	Pulmonary Embolus	Increasing PT's	5 mg (prior to referral) 2½mg after referral 10/69)	27.1 (15.5-47.9)	Digoxin 0.125mgQD Furosemide 80 mg (4 in AM and 3 in PM) Nitrol Ointment 2"QH NTG KCl 16 mEq PRN QD	Possible Drug interactions	[1]Increase contact with patient [2]Closer monitoring [3]Evaluate Furosemide

Discussion

As can be seen in the table, non-compliance was a common problem of several patients. Traditional educational measures, reassurance, and other means to help the patient remember each day's dose have been shown to be very valuable. However, dietary or drug interactions have been difficult to control.

One patient, V.S., presented with a decreasing prothrombin time (down to 14.2 from 18.4 seconds) and gave a history of increased ingestion of green leafy vegetables. Because green leafy vegetables are a potent source of vitamin K,[5,6] dietary interferences were believed to be the primary factor in the decline of her PT. The patient's compliance was also examined as a possible contributing factor.

Normal intake of vitamin K is approximately 300-400 mcg per day. Turnip greens, for example, provide 650 mcg per serving (100 Gm). Accordingly, excessive intake of foods high in vitamin K have been shown to increase the anticoagulant levels needed to maintain a constant prothrombin level. However, if patients are consistent in their intake of leafy vegetables or other foods high in vitamin K, the anticoagulant requirement should not be altered.[5]

Indomethacin is well known to affect the prothrombin time of patients receiving warfarin.[7] Despite persistent education, another patient, M.O., took indomethacin before her appointment on 6/18 with a resulting rise of PT from 23.9 to 32.8 seconds, (2.01 to 2.60 times control). This illustrates the need for continued monitoring and education in order to provide a successful program.

Patient B.H. presents an interesting example of a true drug interaction. Due to the onset of leg cramps, quinine sulfate, 260 mg, and aminophylline, 195 mg, (Quinamm[R]) was begun after initiation of warfarin. Because quinine exerts a mild hypoprothrombinemic effect of its own,[8] the interaction was suspected when the patient's PT rose from 21.5 to 29.5 seconds within the first ten days of Quinamm[R] treatment.

Another interesting drug interaction can be seen in this patient. Because the physician wanted to treat an infection on B.H.'s leg, erythromycin was prescribed for short term therapy. However, no change was made in anticoagulant dosage. The potential for a decrease in vitamin K production due to erythromycin activity,[7] and a subsequent rise in PT, was expected. The patient's PT did rise from 25.4 to 30.9 seconds, which was 2.6 times control. Two weeks after completion of the erythromycin, his PT had fallen to 18.3 seconds.

Patient M.S. was referred because of an increasing PT despite a reduced dose of drug. M.S. was originally placed on a 5 mg dose of warfarin. Dosage was increased to 5 mg every other day, alternating with 7.5 mg,

approximately three months prior to referral. One week prior to referral, the patient's dose was reduced to 5 mg per day. At referral, the patient's PT was 47.9 seconds. Due to the potential for massive bleeding, the drug was discontinued for two days and then resumed at a dose of 2.5 mg daily.

It is interesting to speculate that this patient's PT increase was due to a concurrent increase in furosemide dosage necessitated by worsening congestive heart failure and increasing edema. The dose of furosemide was increased from 80 mg to 560 mg per day over the same period that this patient's PT rose to the value reported.

No interaction between furosemide and warfarin is reported in the medical literature; however, this may reflect a lack of interaction at the lower doses which are most often seen in practice. Perhaps an interference in protein binding becomes clinically significant only at a high dose. Both warfarin and furosemide are highly protein bound (95-99%) which could allow greater displacement of the warfarin, and thus a more pronounced effect on anticoagulation.

Further evaluation of the binding and displacement interaction is indicated. Because of the patient's clinical status, discontinuation and rechallenge with furosemide were considered inappropriate. A reduction in warfarin dosage appeared to be the appropriate alternative; therefore, her dose was decreased to 2.5 mg per day. On return visit the patient's PT had declined to 15.2 seconds. Dosage was then increased to 5 mg, to alternate with 2.5 mg every other day.

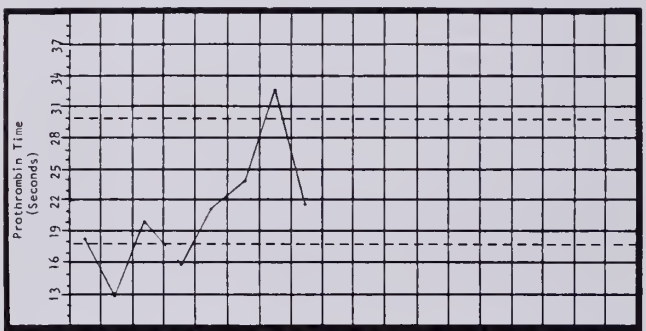
A copy of the anticoagulation record,* which is placed in each patient's chart, is shown in Figure 1. The graph of **Prothrombin Time (in seconds)** vs. the **Date** has been altered to reflect small changes in PT.

COUMADIN® ANTICOAGULANT RECORD NO. ____
(CRYSTALLINE SODIUM WARFARIN)
FOLD FOR 5" x 8" FILING

PATIENT'S NAME M.O. AGE 80 SEX F

ADDRESS _____ PHONE NUMBER _____

DATE COUMADIN (CRYSTALLINE SODIUM WARFARIN) STARTED _____ LABORATORY _____



DATE	1/30	2/8	2/19	3/8	3/23	4/18	6/18	6/29
COUMADIN DOSE (MG)	6	6	6	7.5	7.5	7.5	7.5	7.5

RECORD OF COUMADIN ADMINISTRATION AND LABORATORY DATA
(CRYSTALLINE SODIUM WARFARIN)

DATE	COUMADIN DOSE (MG)	PROTHROMBIN ACTIVITY DATA			COUMADIN NEW DOSE (MG)	REMARKS
		CONTROL (SEC)	PATIENT (SEC)	AS % OF CONTROL		
1/30	6	13	18	138%		
2/8	6	11.9	12.9	108		
2/19	6		19.9		7.5	
3/8	7.5	11.9	15.9	134		
3/23	7.5	11.9	21	176		
4/18	7.5	11.9	23.9	201		
6/18	7.5	12.6	32.8	260		
6/29	7.5	11.6	21.4	184		

A SERVICE OF THE MEDICAL DIVISION—ENDO LABORATORIES, INC., GARDEN CITY, NEW YORK
(FULL DISCLOSURE ON LAST PAGE OF PAD)
ISSUED JANUARY 1974

Conclusions

Evaluation is a major component of the pharmacist's participation in the anticoagulation service.[1] Improved compliance and response can be seen with each subsequent visit.

Four patients are presented who are enrolled in the program. Each patient required individual attention and treatment for the particular problem which affected oral anticoagulant therapy. Since anticoagulant therapy is usually given long term, most patients will require close follow-up and individual intervention. The ACS can monitor patients routinely and work jointly with the physician to evaluate problems and to alter therapy as necessary to maintain the patient's health.

The keys to a successful program appear to be 1) physician acceptance of the abilities of the clinical pharmacist, and subsequent patient referral, 2) proper compliance assessment, and 3) the cooperation of the patient. These may be met by an interest in the patient and his education and a continuing evaluation of the many factors which may influence warfarin therapy.

References available from the author upon request.

*Endo Laboratories, Inc., Garden City, New York.

- Dr. Robinson, College of Pharmacy, J. Hillis Miller Health Center, Box J-4, University of Florida, Gainesville 32610.

Dementia: A Brief Review

John Y. Davenport, M.D.

Abstract: The proportion of aged persons in the United States population is increasing. Dementia is a major problem in this age group. Though most dementias are progressive and untreatable, a significant number of dementias arise from diagnosable, preventable, and treatable causes. Each physician dealing with aged patients should be aware of these treatable forms of dementia in order reasonably to decide when in-depth diagnostic procedures are warranted in the demented patient. A brief review of dementia is presented.

Introduction

In the coming decade, the Family Physician who follows his patients from "cradle to grave" will be faced with an increasing number of aged patients. In the United States, 11% of the population, or 23 million persons, are older than 65 years. By the year 2030, this elderly proportion of the population will increase to 17% (52 million).[1] Florida's population in 1980 is 17% elderly.

Dementia is a major problem in this age group. 4.4% of Americans older than 65 years have serious impairment from dementia.[2] Approximately 11% of persons older than 65 years have mild forms of dementia.[3] There are now approximately one million cases of senile dementia of the Alzheimer's type (SDAT) in the United States, and one half of these require institutionalization.

Persons with chronic dementia occupy long term and acute care beds to a disproportionate degree. There is a direct correlation between brain impairment and decreased longevity.[9] The magnitude of this problem is evident. A brief and selective review of dementia and some of its major causes will be presented in this paper.

The Diagnosis of Chronic Dementia

Dementia is a clinical entity. Any pathologic process affecting the cerebral hemispheres can lead to intellectual impairment.

Chronic dementia is often gross and easily recognized. The patient has impairment of memory, impaired ability to calculate, disorientation to time, place and person, defective judgment, and a labile affect.

Early symptoms of dementia though, are often poorly defined and not obvious. One might first see minor disturbances in the patient's capacity to solve simple problems or a deterioration of the patient's thought processes. Changes are often so subtle that relatives or friends will recognize symptoms before the physician does. As the dementia progresses, though, the disability will become obvious.

Each physician should develop his own routine for recognizing intellectual impairment and assessing mental status. The physician may ask the patient to demonstrate his orientation to time, place, and person; name common objects; demonstrate his fund of common knowledge, such as the names of presidents; interpret proverbs; demonstrate his recent memory; and demonstrate his ability to calculate.

The mini-mental status examination of Folstein et al has proven useful in objectively quantitating cognitive impairment and assessing its progress.[10]

Causes

Chronic dementia can no longer be considered a simple concomitant of "normal" aging. Table 1 lists many of the causes of chronic dementia. Physicians should be aware that in any randomly selected group of chronically demented patients, 10-20% will have diagnosable, often treatable causes.

Jellinger[4] reported autopsies on 1,009 patients with dementia over the age of 55 years. He found Alzheimer's lesions alone in 52.8%; vascular disease alone in 22.5%; both disorders together in 13.6%, tumors in 4.7%, Pick's disease in 2.3%, and hydrocephalus in 1.3%; 2.8% were listed as being of other origins. Tomlinson[5] reported that 48% of his first 140 cases of dementia in persons over 65 years had the changes of Alzheimer's disease alone; 20% had arteriosclerotic lesions of the parenchyma alone; 12% of the specimens displayed both Alzheimer's and arteriosclerotic changes to such an extent that either could have caused the dementia. Another 12% were found to have entirely different causes of their dementia. 8% had no organic lesions that could explain the clinical picture.

Though the majority of dementias listed in Table 1

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are untreatable, some are preventable, diagnosable, and treatable. Each physician must balance the $500-$1,000 cost of a dementia workup against the $15,000 +/year it costs to institutionalize the demented patient.

Alzheimer's Disease

Whether Alzheimer's disease and senile dementia represent two distinct entities has been argued since the first report of Alzheimer's disease in 1907.[11] The pathologic diagnosis of Alzheimer's disease rests upon the presence in the cerebral cortex of senile plaques, neurofibrillary tangles and intraneuronal granulovacuolar degeneration. In many instances, these same changes are found in senile dementia. Alzheimer's disease occurs by definition in the presenium, but the first symptoms of Alzheimer's disease and senile dementia are essentially the same. Most authorities now consider Alzheimer's and senile dementia to be variants of the same process leading to the designation senile dementia of the Alzheimer's type (SDAT).

The etiology of Alzheimer's disease is not presently known, but several hypotheses have been put forward. Increased aluminum content has been found in the brains of patients with Alzheimer's disease and senile dementia of the Alzheimer's type.[12] Aluminum is toxic to certain species of both plants and animals, causing mitotic aberrations and decreased DNA synthesis, among other disturbances. In Alzheimer's disease some regions of the brain have aluminum concentrations approaching 10-30 times the normal average concentration.[13] Other researchers have reported that relatives of patients with Alzheimer's disease are at greater risk for Alzheimer's than the population in general. Whereas the risk in the general population for Alzheimer's disease is well below 1%, the risks for siblings of those with Alzheimer's disease has been reported to be 3.8% and for parents 10%. Some evidence suggests that immunologic mechanisms are important in the pathophysiology of senile dementia of the Alzheimer's type. It has been reported recently that amyloid deposits seen in senile plaques are probably derived from immunoglobulins.[14, 15] Senile plaques increase with aging in non-demented persons but not nearly to the degree seen in senile dementia Alzheimer's type. Thus immunologic mechanisms may be associated with the pathologic process. In other experiments non human primates developed fatal subacute spongiform encephalopathy following an innoculation of brain tissue from two patients with the clinical and hystopathological diagnosis of familial Alzheimer's disease hinting at infection as an etiologic factor.[16]

Table 1

- Alzheimer's disease
- Pick's disease
- Senile dementia (senile dementia of the Alzheimer's type)
- Creutzfeldt-Jakob disease
- Huntington's chorea
- Others: Parkinson's disease, progressive supranuclear palsy, spinocerebellar degenerations, Parkinson-dementia complex of Guam, Hallervorden-Spatz disease.

- Arteriopathic dementias:
- Cerebral hypoxia
- Metabolic diseases: myxedema, hypoglycemia, chronic hepatic disease, uremia, Wilson's disease
- Nutritional diseases: Wernicke-Korsakoff syndrome, vitamin B12 deficiency, Pellagra
- Heavy metal intoxication (lead, mercury, manganese)
- Normal pressure hydrocephalus
- Neoplasms
- Trauma
- Infections of brain

Cruetzfeldt-Jakob Disease

Cruetzfeldt-Jakob disease is a rare dementia which usually becomes apparent between 40-60 years of age. Cruetzfeldt-Jakob may present with any of the symptoms of dementia including personality changes, anxiety, depression and intellectual and memory impairment. Liability of affect, and visual hallucinations are frequent. Neurologic symptoms indicating focal disease may develop in later phases. The usual course of this disease is measured in months.

The etiology of Cruetzfeldt-Jakob is unknown, however, virus like particles have been demonstrated by electron-microscopy, and the disease has been transmitted from man to monkey.[17] Duffy et al[18] reported human to human transmission by corneal transplant. Viral particles were demonstrated in the cornea.

Huntington's Chorea

Huntington's disease is an inherited dementia characterized by choreic motor activity affecting general movement and mental alterations occurring in the third and fourth decades of life. The genetic pattern of Huntington's chorea is clear. The mode of inheritance is by simple mendelian autosomal dominant. The disease progresses slowly with a survival of 15 to 20 years after onset.

Multiple Infarct Dementia

As noted in the autopsy studies cited in this paper, dementia caused by vascular disease alone accounts for a significant number of cases. Progressive dementia related to vascular disease is most frequently associated with multiple small cavities (lacunes) in the basal ganglia, periventricular white matter, thalamus, and pons. At any one point in time, the clinical picture of multi-infarct dementia may be indistinguishable from that of Alzheimer's disease, though over a period of time there is a tendency for step-wise progression in multi-infarct dementia.

Cerebral Hypoxia

Gray matter is more severely affected by anoxia than white matter. Any disorder which reduces the

supply of oxygen to the brain may result in dysfunction of the nerve cells and dementia. Reduction of oxygen can occur as a result of cardiac arrest, impaired respiratory function, decreased ambient oxygen, slowing of the circulation, and poisoning. The degree of neurologic impairment is related to the duration and type of anoxia encountered, and recovery may be complete or partial after the cause of anoxia has been removed.

Metabolic Diseases

A wide variety of metabolic disorders can lead to dementia. Hypothyroidism can produce a wide variety of symptoms including headache, ataxia, incoordination, hallucinations, depression, paranoia, maniacal behavior, and others. Repeated attacks of hypoglycemia occuring most frequently in labile uncontrolled diabetics can lead to progressive impairment of memory and general intellectual ability. Focal deficits may also be present. Hepatic dysfunction may lead to dementia. The brain contains a powerful mechanism for detoxifying ammonia, but in hepatic encephalopathy, the brain's ability to detoxify ammonia is overcome so that free ammonia spills into the brain to interfere with intercellular respiration.[19] Many other factors remain to be fully clarified in hepatic encephalopathy, but much data suggest that ammonia is directly toxic to the brain and is primarily responsible for the dementia in hepatic encephalopathy. Other metabolic causes of dementia include Wilson's disease, acute intermittent porphyria, adrenal and parathyroid disorders, uremia, and chronic dialysis induced dementia.

Nutritional Diseases

Korsakoff's Syndrome is characterized by disturbed recent memory, intellectual impairment and confabulation in a patient with a history of excessive alcohol consumption. There is thought to be a relationship between thiamine deficiency and the mental symptoms of Korsakoff's Syndrome. Any of the initial mental symptoms might be reversed rapidly by the administration of thiamine. Once the symptoms of Korsakoff's psychosis are established, however, complete recovery occurs in only a small proportion of patients (approximately 20%). Most patients experience some improvement of their symptoms with a maximum degree of recovery evident after approximately one year.

Vitamin B_{12} deficiency can cause dementia in the absence of megaloblastic anemia or any clinical evidence of subacute combined degeneration of the spinal cord.[8] The dementia of B_{12} deficiency may demonstrate periods of remission and thus mislead the clinician into believing he is dealing with a functional disorder. A serum B^{12} level, intrinsic factor or antibody, and Schilling test should allow diagnosis and effective therapy.

Since 1940 the prevalance of pellagara has diminished greatly. Pellagara with its clinical features of dermititis, glossitis, stomatitis, diahrrea, and dementia has been virtually eradicated by the fortification of bread and cereals with niacin.

Drug Intoxications

Several heavy metals have been indicated as causes of dementia, including lead, mercury, and manganese. Intoxications of this nature produce symptoms characterized by irritability, emotional instability, intellectual impairment, incoordination, pyramidal dysfunction, and occasionally focal neurologic symptoms.

Normal Pressure Hydrocephalus

First described by Hakim and Adams in 1965[6] normal pressure hydrocephalus is characterized by dementia, incontinence, and gate disturbance. There is x-ray evidence of enlarged ventricles with normal cerebral spinal fluid pressures and often improvement with shunting.

There are two forms of normal pressure hydrocephalus. The first is secondary to lesions which produce obstructive hydrocephalus. Approximately 60 percent of these patients show improvement after shunting.[7] In the other form, idiopathic normal pressure hydrocephalus, an obvious etiology of hydrocephalus is not apparent, but they otherwise fit the syndrome of normal pressure hydrocephalus. Reports vary, but approximately 40 percent of these patients respond favorably to shunting.

Mortality following shunting may be as high as 69 percent with shunt related complications affecting 40 percent of patients. This complicates the physician's decision as to whether to recommend treatment in this condition.

Further complicating the diagnosis of normal pressure hydrocephalus is the fact that approximately 10 percent of patients with Alzheimer's disease have severely dilated ventricles and abnormalities in their pneumoencephalograms, their CT scans, isotopic cisternography, and infusion manometric testing suggesting that they might have a communicating hydrocephalus.[20] Clinically Alzheimer's disease presents with dementia first, whereas normal pressure hydrocephalus often presents with gate disturbance first.

Neoplasm

Dementia must always alert the physician to the possibility of brain neoplasm. Neoplasm may be evidenced by focal neurological signs, evidence of increased intracranial pressure, behavioral changes, and dementia. Jellinger[4] reported a tumor instance of 4.7 in his autopsy series of 1009 patients.

Trauma

Trauma is an infrequent cause of dementia unless there is considerable loss of brain tissue. In older patients, seemingly insignificant or inapparent trauma may lead to subdural hematoma formation with subsequent progressive dementia. Headache sometimes accompanies this syndrome but its absence does not exclude the diagnosis.

Infection

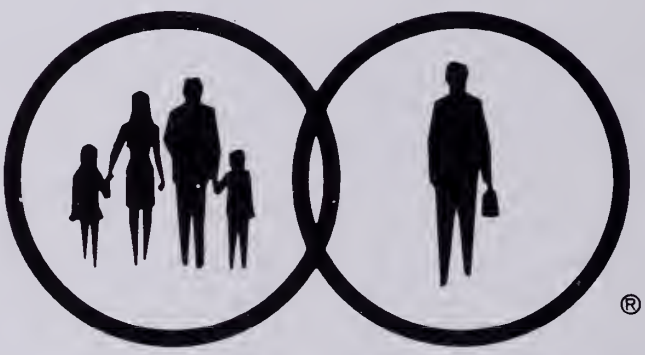
Symptoms of dementia may be observed in the acute and recovery phases of acute bacterial, tuberculous, and fungal meningitis. Viral meningitis and encephalitis does not often produce persistent dementia except as a sequel to severe inclusion body varieties, for example, herpes simplex. Dementia paralytica occurring usually 10-20 years after the original infection with treponema pallidum is rarely seen at the present time.

Conclusion

The proportion of aged persons in the United States population is increasing. Dementia is a major problem in this age group. Though most dementias are progressive and untreatable, a significant number of dementias arise from diagnosable, preventable and treatable causes. Each physician dealing with aged patients should be aware of these treatable forms of dementia in order to reasonably decide when in-depth diagnostic procedures are warranted in the demented patient.

References available from the author upon request.

• Dr. Davenport, 1842 King Street, Jacksonville 32204.



Anemia of Chronic Disorders: More Common Than Commonly Appreciated

R. Whit Curry Jr., M.D.

Introduction

Anemia is a common disorder in hospitalized patients. A random survey of 200 family practice patients admitted to a community hospital demonstrated that twenty-eight percent (28%) of patients were anemic on admission. Table 1 shows the most common cause of anemia in these patients was a chronic disorder—the so called anemia of chronic disorders (ACD). The second most frequent type of anemia, that associated with renal failure, has much in common with ACD but will not be included in the following discussion. This paper will (1) describe ACD, (2) discuss possible etiologic mechanisms, (3) propose a schema for diagnosis, and (4) mention therapeutic alternatives.

Description

ACD is synonymous with "simple chronic anemia," the "anemia of infection," and a variety of other terms including the tongue twister, "sideropenic anemia with reticuloendothelial siderosis." It is almost invariably a consequence of chronic infection, inflammation, and/or neoplastic disease. It frequently is seen in connective tissue disorders, trauma, fractures, and a variety of miscellaneous conditions.[1] Despite its association with a heterogenous group of disorders, ACD is "lumped" into one diagnostic category because it is characterized by a number of specific features.

ACD is usually mild to moderate with hematocrit values ranging between 27% and 35%, although values as low as 20% have been reported. The severity of ACD is roughly proportional to the severity of systemic symptoms such as fever, weight loss, and general debility. The anemia usually develops during the first several months of illness following which hemoglobin levels generally remain constant.[2]

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Etiology

ACD is primarily a production anemia with a reticulocyte count which is inappropriately low for the degree of anemia. Although there frequently is also a modest shortening of red cell survival time, a normal bone marrow would readily compensate were not decreased production the major factor responsible for ACD.[3]

The underlying reason for an inadequate marrow response in ACD is unclear. Decreased erythropoietin secretion and/or an impaired marrow response to erythropoietin have been suggested as contributing factors. Douglas and Adamson[4] postulate that the availability of useable iron in the marrow may be the primary factor limiting erythropoesis. Ferrokinetic studies demonstrate that in many ways ACD resembles iron deficiency anemia with a decreased serum iron, decreased percentage transferrin saturation and decreased transferrin, rapid clearance of radio-iron from the plasma, increased iron utilization, and elevated free erythrocyte protoporphyrin levels. Several studies have demonstrated the marrow red blood cell production is only as effective as would be predicted from the serum iron level,[4] again implicating iron as a limiting factor in ACD.

The bone marrow in ACD shows increased iron in reticuloendothelial (RE) cells but a decrease sideroblasts (iron containing red cells precursors). This combination of findings is peculiar to ACD and suggests that iron, although plentiful within the RE system, remains relatively unavailable to erythrocyte precursors. Iron appears to be trapped in RE cells, the so-called reticuloendothelial block, associated with a fall in serum iron and transferrin. As developing red cell precursors obtain their iron for hemoglobin production via binding of transferrin,[5] a decrease in transferrin results in decreased availability of iron to red cell precursors. Indeed, a low serum iron and transferrin is a sine qua non for the diagnosis of ACD.[1]

A majority of patients with ACD have hypochromia, and the values for mean corpuscular volume (MCV) and

mean corpuscular hemoglobin concentration (MEHC) are quite similar in patients with ACD and iron deficiency. ACD is frequently hypochromic and normocytic, sometimes normochromic and normocytic, or occasionally hypochromic and microcytic.

Diagnosis

Although ACD is seen in a heterogenous group of disorders and carries a rather nonspecific name, it is a diagnosis that can, and should, be made quite precisely. First, it is a production anemia with a reticulocyte count inappropriately low for the degree of anemia. Second, it is of mild to moderate severity and appears morphologically similar to iron deficiency. Third, the serum iron and iron binding capacity are low. And fourth, the bone marrow is normal cellularity with normal to increased iron present in reticuloendothelial cells. Other characteristic features include a normal or increased serum ferritin, increased plasma copper, and increased free erythrolyte protoporphyrin. The triad of decreased iron, decreased iron binding capacity, and increased reticuloendothelial iron in the bone marrow has not been observed in other conditions and can be considered diagnostic for ACD.[2]

A frequent clinical dilemma occurs when a chronically ill patient has a production anemia accompanied by a low serum iron and decreased iron binding capacity. Here the chief diagnostic considerations are ACD versus iron deficiency, and neither the serum iron, iron binding capacity, or percent saturation will reliably distinguish the two.[5] A bone marrow examination will clearly differentiate ACD from iron deficiency but is uncomfortable and costly. A second alternative, a therapeutic trial on iron, will take at least one week, frequently results in GI distress, and may still yield equivocal results. Frequently a serum ferritin at this point will obivate the need for either of these choices.

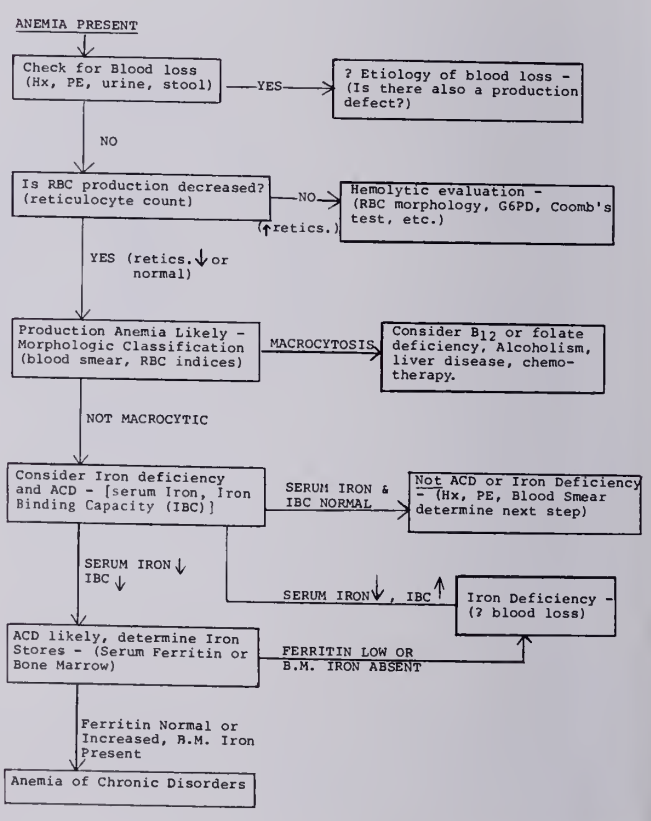
Ferritin is a complex iron storage protein. Its level in the serum has been shown to correlate closely with reticuloendothelial iron stores and in normal subject can be considered a reliable index of iron stores.[6,7] In patients with chronic disease a low serum ferritin (less than 20 nanograms percent) is a reliable indicator of iron deficiency. Although it may rise to within normal range **despite** iron deficiency in some patients with hepatic necrosis or inflammation,[7,8] a high normal value (greater than 100 nanograms percent) reliably excludes iron deficiency. If the serum ferritin is intermediate or nondiagnostic a bone marrow examination remains the most reliable and readily available test to assess iron stores. Figure 1 diagrams a suggested diagnostic approach.

Table 1
A Random Survey of 200 Patients
Admitted to a Family Practice Residency Inpatient Service

Patients with anemia on admission		**55**	**(28%)**
ANEMIA DIAGNOSIS			
Anemia of Chronic Disorders		**15**	**(27%)**
Etiology: Carcinoma	4		
Diabetes Mellitus with Chronic Infection	4		
Chronic alcoholism with cirrhosis	2		
Frostbite	1		
Aspiration pneumonia	1		
Multiple myeloma	1		
Adhesive arachnoiditis	1		
Pelvic absess	1		
Anemia of Renal Failure		**14**	**(25%)**
Blood loss anemia		**14**	**(25%)**
Unknown or undiagnosed		**5**	**(9%)**
Iron Deficiency (without obvious blood loss)		**3**	**(5%)**
B_{12} Deficiency		**1**	
Pregnancy (probable folate deficiency)		**1**	
Sepsis		**1**	
Leukemia		**1**	

Figure 1

Suggested Diagnostic Approach to Anemia



There is currently no effective therapy for ACD other than treatment of the underlying disease. Oral or parenteral iron is ineffective and only results in further iron overload. Theoretically a constant I.V. infusion of

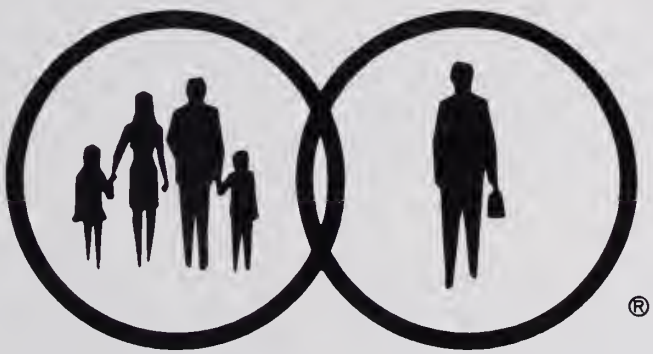
iron-saturated transferrin should be effective, but such a preparation is currently unavailable. Recent studies suggest that improving nutritional status may increase hematocrit in these patients, possibly by increasing transferrin.[9] Cobalt has been shown to improve ACD but is unacceptable because of its toxic effects. Stimulators of erythropoesis such as erythropoietin or androgens might increase the rate of red cell production but could aggravate the hypoferremia and thereby be of questionable therapeutic benefit[1] Thus it appears that drug therapy of ACD should be avoided. In the rare patient who becomes symptomatic (underlying coronary artery disease, pulmonary disease, etc.) transfusion of packed red blood cells is probably the best therapy. In the vast majority of patients with ACD the mild to moderate anemia is not harmful and best go untreated until a safe and effective therapeutic modality is available.

Summary

ACD is common in family practice, occurs in many clinical settings, is probably due primarily to a disturbance in iron metabolism, and can readily be diagnosed as discussed above. Clinically it is important to diagnose ACD—not because effective therapy is available—but because patients with chronic diseases may have other treatable causes of anemia which will be discovered or excluded in the diagnostic evaluation for ACD. Hopefully, as we better understand the etiologic mechanisms in ACD, safe and effective therapeutic modalities will become available.

References available from the author upon request.

- Dr. Curry, Box J-222, J. Hillis Miller Health Center, University of Florida, Gainesville 32610.



Family Practice in a Large Multi-Specialty Group

Donald G. Nikolaus, M.D.

Small Group

After completing a rotating internship in 1956, I still had a military commitment. My internship terminated June 30 that year, and I did not have to report for active duty with the United States Air Force until November. For the intervening four months I joined a group practice in a small town, Dunedin, Florida. Dunedin's population at that time was 3,100. Mease Hospital and Clinic occupied a single building. The group included four family physicians, one internist, one general surgeon, one OB-GYN specialist, and a urologist. Each physician had one room to work in, and I covered for physicians who were on vacation or not immediately available.

Air Force Years

My military experience provided a good family practice education. This introduction to the practice of medicine was accomplished without the worries of office management, the concerns of billing, the frustrations of forms, and the general problems associated with administration.

I began my military service with the United States Air Force as a duty officer in an outpatient clinic. After nine weeks in Flight Surgeon's School at Randolph Air Force Base in Texas, I went to Tyndall Air Force Base in Florida as a flight surgeon.

Large Group

On returning to Dunedin after my Air Force years, not only had my family grown from two to four, but the Mease Hospital and Clinic had grown in number of buildings and in size of the physician group.

At this writing the group includes 15 family physicians, 18 internists including nephrologist, diabetologist, cardiologist, gastroenterologist, chest specialist, rheumatologist, endocrinologist, dermatologist, two oncologist, five generalists, and three urologists. In addition there are two general surgeons, two chest and thoracic surgeons, and three orthopaedic surgeons. Besides these there are three ophthalmologists, two ear, nose and throat specialists, four radiologists, two pathologists and three pediatricians. The town has also increased in size to 35,000.

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Percent of Fees Collected

Large groups of physicians are set up different ways; Mease may be unique. The hospital and clinic comprise one corporation. For a percentage of fees collected, the corporation provides to the practicing physicians office space, staff, equipment, and supplies. New physicians do not have to buy into the group, and they have a ready source of new patients. An advantage of a large group is the availability of a staff large enough to handle most administrative headaches.

Medical Records

Outpatient and inpatient information is contained in separate charts in one record room. The outpatient medical record is a modified problem-oriented record. Record keeping systems vary among physicians. There is no required system. We have attempted to standardize medical records, but each physician may determine his own format.

Outpatient Charts

Copies of inpatient informtion such as histories and physicals, discharge summaries, and consultations are automatically included in the outpatient chart. The inpatient chart is readily available. Dictation facilities are available for reports and letters. A central stenographic pool performs this service for inpatient and outpatient responsibilities.

Forms

Insurance forms, workers' compensation forms, Medicare forms, and Medicaid forms are handled in a centrally located area to decrease errors and conflicting reports. Copies of these forms are included in the outpatient chart.

Patients are provided with advice and information on outpatient insurance and Medicaid forms. Billing is done centrally by computer. Inpatient and outpatient billing is separated, but the same computer handles both. Current billing and payment information is readily available.

Laboratory and X-ray

Laboratory services for both inpatient and outpatient sertvices are provided by the same laboratory and allows very complete laboratory services to be provided. X-ray services for inpatient and outpatient care are provided by up-to-date radiologic equipment and enhance delivery of high quality health care.

Ancillary Services

Physiotherapy, respiratory therapy, social services, and dietary consultation are services available to both inpatients and outpatients. Having one's medical office in the same building with the hospital has the advantage of accessability. It is usually a simple procedure to get a very ill patient to bed in the hospital rather quickly. Likewise, if hospitalized patients develop serious problems, they can be checked quickly by the physician after a short walk to the hospital.

Emergency Room

The emergency room is staffed full time and can be used by the medical staff for prearranged visits when the medical office is closed. If the physician wishes, the emergency room doctor will see the patient and help decide if admission is necessary.

Conference Room

Another asset of the large group is the conference room equipped with steam tables where all the physicians have lunch. Hours are from 12 noon until 2:00 p.m. This allows frequent informal consultations and discussions about problem patients and unusual findings. Many meetings are held here. Few weeks pass without at least one scientific program occurring, such as "Great Cases of the Month" in which a physician with an unusual or interesting case can be presented and include x-rays, electrocardiograms, echograms or similar graphics. There is a monthly death conference in which deaths of the preceding month are reviewed and one or two of the more interesting cases discussed. At the monthly general staff meeting, retired physicians in the area are invited as well as all hospital physicians; usually an outside speaker gives a talk. Tumor Conference is held and a team approach is used to determine appropriate workup and treatment for cancer patients.

Disadvantages

Even with all these advantages there can be some disadvantages associated with a large group. Congeniality is necessary if a large group is to function well. Careful screening of applicants for membership in the group helps to avoid many problems which might otherwise develop.

Ancillary Service Income

I do not derive any income from ancillary services. Some would consider this a disadvantage but I look at it in a different way. Ordering laboratory work, x-rays, or physiotherapy for a patient does not make more income for me. I am reimbursed on a percentage of my fees that are collected. This means I am being paid only for the medical services that I render. My income has never been of concern to me. There has been more than enough work to go around. I can work as much as I want to, and am paid well on a fee for service basis for the work I do.

Our Patients Benefit

I have not found many disadvantages associated with practicing medicine in a large group. I have practiced in the same location since my return from military service in 1958. I consider working in a large group a great professional experience, and I believe that our patients benefit greatly from the many advantages we are able to offer.

Summary

A physician working in a large multi-specialty group can avoid many administrative headaches, forms, and fiscal concerns. A well-equipped laboratory, x-ray, physiotherapy, respiratory therapy, social services, dietary departments serve both inpatients and outpatients. Frequent conferences and readily available consultation services make the practice of medicine a continuing medical education experience which benefits all patients.

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The Relational Model
A Paradigm of Family Medicine

Lynn P. Carmichael, M.D.

Some authors have held that primary care is a service rather than a concept, and it is the services provided, not the physician or the specialty that determine its value and success. Nonetheless, competition and strife continue to characterize the relationships between specialists, such as internists and pediatricians, and the family practitioner. An analysis of studies comparing the specialties of internal medicine and family practice indicated that while the services provided may be the same, there are major differences in the way they are provided and that these differences have significant implications for the quantity and cost of care. Furthermore, studies fail to confirm the fear expressed by Moloney and Rogers that the "too broadly but shallowly trained generalist could become the source of the increased use of medical technologies through specialty consultations." In the following article I contend that the differences between the primary care specialties relate to the medical disciplines employed in providing primary care, and that family practitioners rely heavily on the discipline of family medicine. The conceptual framework for understanding the discipline of family medicine is illustrated by means of a relational model.

Family Medicine as a Discipline

In other papers, I have attempted to clarify the meaning and differences between an academic discipline, a specialty and medical practice. Stephens maintains that family medicine as a discipline meets the criteria developed for intellectual responsibility, and Richardson states it qualifies as an independent university discipline on the basis of its distinctive morbidity, techniques of analyses, philosophy and research. This theme has been expanded by McWhinney. Medalie has explored the impact of the life cycle for family practice and Marsland, Wood, and Mayo tabulated the various problems encountered by the family practitioner; and Huygens recent work is hailed as a prototype of family medicine research.

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One approach to understanding the nature of medical practice is through the use of a conceptual model or paradigm. Conceptual models have been used by Lazare in explaining clinical psychiatry and by Friedson in a study of prepaid group practice. When using models it is important to bear in mind that they are intellectual propositions and not factual descriptions of phenomena. Friedson supports this interpretation when he states, "But since they are solely models — which is to say local constructs, aids to systematic thinking rther than descriptions — they are not embodied in pure form in any social policy or, for that matter in any productive enterprise." Lazare cautions that, "No model offers a complete explanation of the phenomena to which it addresses itself. Any two conceptual models may offer alternative explanations for the same behavioral events. In applying more than one conceptual model in treating a given patient, we must recognize the possibility of apparent contradictions."

By using data gathered through surveys and direct observations of doctor-patient encounters, I have derived three conceptual models within family/general practice. Clinical relational and adversarial models are all present, however, it is the relational model which forms the predominant paradigm for the practice of family medicine as it relates to primary care.

Observations from Family Medicine

An analysis of professional satisfaction of family/general practitioners by Joan Carmichael identified characteristics of the doctor-patient relationship. These characteristics are listed and described in Table #1.

The clinical model, based on the types of problems brought to the doctor by the patient with a progressive disorder consists of four characteristics: activity, authority, objectivity and rationality. The relational model, based on patients with self-limited disorders, psychosocial problems and prevention oriented encounters is characterized by affinity, intimacy, reciprocity and continuity. The last conceptual model, labeled as the adversarial model, relates to patient visits for administrative type problems and consists of characteristics referred to as "other" since they were too few in number to be statistically identified.

Conceptual Models of Family Practice

Using data from the National Ambulatory Medical Care Survey regarding the type and frequency of problems encountered in family/general practice, the diagram illustrated in Figure #1 was constructed.

It is important to emphasize that the three conceptual models are not an operational strategy for providing care or services by the family physician, but are a way of gaining clear comprehension of what happens in family practice. As noted on the diagram, 15% of the encounters in family practice relate to the clinical model in which the patient has a progressive disease or an injury that in all likelihood, if left untreated, may result in either death or significant disability. The relational model, encompassing 80% of the encounters, concerns self-limited disorders (35%), psychosocial problems (35%) and preventive measures (10%). The adversarial model accounts for 5% of the encounters and relates to administrative purposes or activities. These three conceptual models are compared in Table #2.

Table 1. — Characteristics of the Doctor-Patient Relationship

Activity
The need for the general practitioner to take diagnostic and therapeutic action in managing the patient's problems.

Affinity
This refers to the formation of a bond between the doctor and the patient.

Authority
The practitioner's utilization of special medical knowledge and skills in the diagnosis and treatment of illness.

Continuity
The provision of health service to a patient by a specific physician over a period of time and for more than a single episode of illness.

Intimacy
A close, friendly, personal relationship based on familiarity, trust and acceptance.

Objectivity
Treating the events or phenomena associated with illness as external or pertaining to reality rather than as affected by personal relations or feelings; use of facts without distortion by personal feelings or prejudices.

Rationality
The provision of medical care based on reason or general scientific principles.

Reciprocity
A professional relationship in which there is mutual communication, sharing, exchange and interdependency between the doctor and the patient.

Other
This includes aspects not covered by the above concepts.

The Clinical Model

The clinical model is oriented toward goals and values and there is an attempt to achieve a socially agreeable and desirable goal through the management of illness. This goal is highly valued by a large part of our society. The objective in the clinical model is to cure or at least to control disease. Accordingly, objective measurement of the quality of care given in the clinical model is based on the result or outcome produced by the management of the illness. The relationship between physician and patient is that of provider and recipient and is similar to a relationship between a teacher and student or parent and child. The characteristics of the clinical model are activity, authority, objectivity, and rationality. Authority requires the special knowledge and competencies of the physician. Activity describes the role of the physician in carrying out the management of the problem by performing procedures, writing prescriptions or other direct actions. Objectivity in the clinical model describes the psychological set of the provider and the way in which a physician relates to the patient dispassionately and unemotionally. Rationality is the physician's adherance

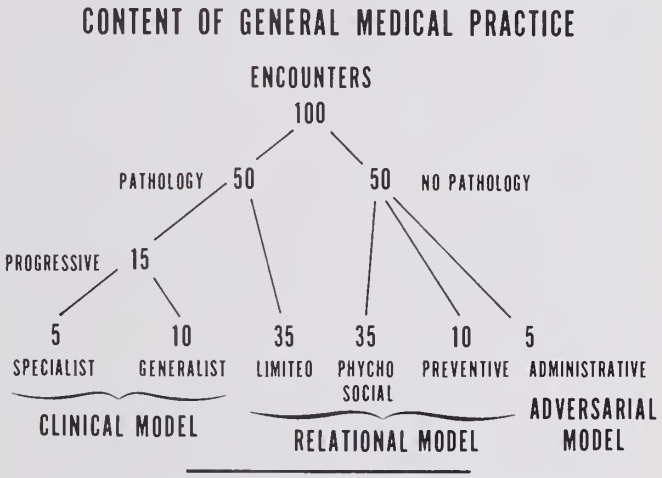


Figure #1

COMPARISON OF CONCEPTUAL MODELS IN FAMILY PRACTICE

	CLINICAL	RELATIONAL	ADVERSARIAL
PERCENTAGE	15%	80%	5%
ORIENTATION	VALUES AND GOALS	RIGHTS AND DUTIES	PRIVILEGES AND SANCTIONS
OBJECTIVE	CURE/CONTROL	CARE/COMFORT	CERTIFY
RELATIONSHIP	PROVIDER/RECIPIENT	PARTICIPANTS	ANTAGONISTS
EVALUATION	OUTCOME	PROCESS	STRUCTURE
CHARACTERISTICS	AUTHORITY ACTIVITY OBJECTIVITY RATIONALITY	AFFINITY INTIMACY RECIPROCITY CONTINUITY	ENTITY BREVITY ANIMOSITY LEGALITY

TABLE #2

to an established school of therapeutic endeavor rather than by the use of an empirical or "whatever works" approach. Examples are asepsis and hemostasis in surgery or confirmation of disease states from laboratory and other technological examinations.

The Relational Model

The relational model focuses on rights and duties and is not oriented toward the achievement of a particular goal. Since the clinical outcome is not in question, or rather, cannot be said to be altered ultimately by the action of the physician, services are provided not curative or controlling but simply provide comfort to the patient until resolution occurs. Thus, the measure of the quality of care in the relational model is based on giving care rather than on outcome. The relationship between physician and patient is that of adult and adult, and the two become participants in a process. The characteristics of the relational model are affinity, intimacy, reciprocity, and continuity. Affinity refers to the bond between the doctor and the patient. Intimacy describes the openness and trust that develops in the relationships. Reciprocity relates to the mutual sharing, the giving and taking, or interdependency of doctor and patient. Continuity is the expectation that the relationship will continue over an indefinite period and the absence of need for contingency plans.

These four characteristics — affinity, intimacy, reciprocity and continuity — may also describe the relationships in a family unit. It has been held that the "family" in family medicine relates to the form of the physician-patient relationship rather than to the care of the family as an entity.

The Adversarial Model

Adversarial situations are the most troublesome of the three conceptual models commonly encountered in family practice. Education and training condition the physician to expect the patient to ask for help with an illness or injury. However, in the adversarial model, the patient is not asking for help but comes to the physician because he or she is licensed by society to prescribe drugs, certify disability or perform certain other administrative duties, and because such services cannot be legally obtained elsewhere. The orientation of the adversarial model is toward sanctions and privileges with the objective of certification. To measure the quality of care in the adversarial model one must assess structural aspects such as legislation and formal society expectations. The relationship between physician and patient in the adversarial model consists of entity, brevity, animosity and legality. An entity is what the patient seeks to attain, such as a piece of paper in the form of a certificate or prescription. Brevity refers to the desire of both participants to keep the encounter as short as possible. Animosity describes the attitudes of both parties; and legality the legislative origin of the physician-patient encounter.

Identification of the Predominate Model

With the occasional exception of the adversarial encounter, none of the three models exist in pure form in actual medical practice. Elements of all three models are usually present in most patient encounters. In the aggregate, the relational model is the dominate aspect of patient care in family/general practice. It is the dominance of the relational model that differentiates primary care provided by the family/general physician from that provided by the internist/pediatrician.

Conclusion

This paper attempts to differentiate the types of primary care rendered by a family physician and that of other categorical specialists. Differences are described through the construction of a conceptual framework and the use of the relational model as the apparent dominant approach in family medicine. The relational model thus becomes the paradigm for family practice. The existence of the paradigm provides a basis for the elaboration of the principles of the discipline of family medicine. Application of these principles in primary health care constitutes the involvement of family medicine and makes it possible to orient students to the relational model concept and to evaluate its use by practitioners.

References available from the author upon request.

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Alternative Methods of Healing: Biofeedback

Jack C. Hartje, Ph.D.

Abstract: The demands of the contemporary environment are producing a steady increase in the incidence of stress-related disorders. Traditional medical practice has favored a pharmacological solution to these disorders. Several alternatives to this traditional approach are noted, and biofeedback is discussed in some detail. Biofeedback is basically a learning therapy in which involuntary responses are gradually brought under voluntary control. This is facilitated through the use of electronic machines which continuously monitor some physiological state (such as skin temperature) and provide instant feedback to the learner whenever the measured state changes. With this information, voluntary control becomes possible.

Among the successful applications of biofeedback, headache control is the most popular. Muscle contraction headaches respond well to electromyographic (EMG) feedback and migraine headaches are responsive to thermal feedback. Other applications including low back pain, stroke, and epilepsy are discussed. It is concluded that under proper conditions, biofeedback should be considered a viable alternative to traditional, drug-based therapy.

Estimates by the American Medical Association indicate that 50 to 80 percent of ailments needing medical treatment are stess-related (Pelletier, 1977). As a result of a number of excellent studies, much has been learned in the past 50 years about the relationship between sustained stress and pathological conditions. This paper discusses the relationship between stress and disease, and focuses on a therapy which promises to ameliorate the effects of stress.

All individuals are not equally stressed by the same stimuli. Most stressors are a product of the current environment combined with previous conditioning. An X-rated movie, for example, may be extremely stressful to some individuals and quite enjoyable to others. It is important to recognize that conditioning plays a major role in stress responses. To the extent that stress responses are conditioned, it is possible to decondition these same responses. When a stressful stimulus is identified by an individual, several psychophysiological events rapidly take place. These events include, but are not limited to, hypothalamic stimulation of the pituitary via vascular and neural pathways. Pituitary ACTH stimulates the endocrine system and has especially important effects on the adrenals. While endocrine output is increasing, the sympathetic division of the autonomic nervous system becomes dominant. These two systems, the endocrine and autonomic nervous systems, account for most changes associated with stress responses.

Although the stress response when seen as a product of evolution is much to the individual's advantage, current environmental changes, such as the industrial revolution and mechanized lifestyle, have suddenly made the stress response, in many cases, counterproductive. We no longer need excessive adrenaline to allow us successfully to outrun the dinosaur. We have become civilized and have attempted to bring our emotional responses under control. It is this contradiction between the physiology which automatically causes changes to take place within the body and the environmental demands outside the body that is the basis for stress produced pathological conditions. We are well equipped to tolerate short-term stressors, but are likely to develop illness under extended periods of stress.

Stress Therapies

There are many therapies which deal with the undesirable effects of stress. Medical intervention is typically based in pharmacology. Anti-stress drugs can have a marked effect on the physiological mechanisms of stress. Under conditions of short-term stress, such as a death in the family, there seems to be no reason to avoid the prescribing of anti-stress drugs. This paper favors the short-term use of such drugs. Unfortunately, some individuals become physically and psychologically dependent on these drugs and take them routinely for many years. It is this type of behavior which led to the development of alternative methods of treating stress responses. In 1979, more than 50 million prescriptions

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were written for Valium (Hartje, 1980) in the United States. These data indicate a national problem, and this paper discusses alternatives to excessive drug use.

Although the purpose of this paper is to discuss biofeedback, other therapies need to be acknowledged. Hypnosis, autogenic training, lifestyle modification, and meditation can be effective alternatives to excessive drug use. All have been demonstrated to be useful in certain contexts.

Biofeedback was developed for clinical use in the early 1970's. The remainder of this paper will discuss this newcomer to the field of stress management.

History of Biofeedback

Prior to the introduction of biofeedback, most researchers agreed that voluntary control of autonomically mediated responses was impossible. In the 1950's, research with animals showed that if the organism could be made aware of moment-to-moment changes in a particular body system, then some degree of voluntary control could be exercised. In other words, it became apparent that those body functions which are under voluntary control also happen to be functions which provide natural feedback. Body functions deemed involuntary are functions which provide little or no natural feedback.

A hypothesis was presented concerning the role of feedback in voluntary control. What would happen if the missing natural feedback was artificially provided through some type of mechanical arrangement? Would this allow voluntary control?

Early work indicated that rats could gain voluntary control over heart rate and blood pressure if heart rate and blood pressure were continuously monitored, changed into some easily understood signal, such as a tone, or, in the case of animals, reinforcement, and made available to the learner. Rats, for example, were reinforced for slight changes in blood pressure. Under these conditions, rats could learn to modify their blood pressures in the direction being rewarded. Heart rate could also be brought under voluntary control (Hartje, 1980). Later work with humans indicated that the same type of voluntary control could be exercised if a simple tone was introduced whenever the desired change took place. This early work laid the foundation for what would later be called biofeedback. Biofeedback is, therefore, a process of feeding back to its source information about biological changes. When this information is provided in a simple format, voluntary control becomes possible.

Biofeedback Technology

Biofeedback falls into several different categories. Electromyographic (EMG) biofeedback involves the use of an electromyograph which has been modified so that a tone tracks changes in muscle activity. A specific example might involve attaching EMG sensors to the frontalis muscle and providing continuous feedback contingent upon slight changes in muscle activity. Any increase in frontalis tension would be immediately translated into a rising tone. Slight decreases in muscle activity would be immediately translated into a lowered tone. The individual would be instructed to do whatever was necessary to cause the pitch of the tone to drop. Under these conditions, most individuals are able quickly to produce a significantly lower tone. Thermal and EEG feedback are discussed elsewhere in this paper.

Biofeedback Applications

There are many uses for EMG biofeedback. Among these is the treatment of one of the most commonly heard complaints in a physician's office — "I have a headache." Although not all headaches are due to muscle contractions, it is well known that most headaches are the result of nothing more than sustained muscle contraction in the neck and head area. By providing EMG feedback for these muscle groups, individuals with muscle contraction headaches can be taught to relax these muscles and thereby prevent future headaches. The success rate for the use of biofeedback in headaches is quite high, and both the national literature and clinic experience indicate that this is appropriate therapy.

Other uses for EMG feedback include the reduction of lower back pain through spasm control and the rehabilitation of impaired muscles following some type of trauma such as stroke. The post-stroke patient, when asked to move an impaired limb day after day during physical therapy, often loses motivation to continue therapy. By simply attaching an EMG to the affected muscles, the therapist and patient can be immediately aware of any motor neuron activity. This is crucial in the rehabilitation program because the EMG feedback machine detects successful motor neuron firings long before movement becomes apparent. The EMG bridges the gap between the actual stroke and the first observable motion.

Another form of biofeedback involves thermal feedback. Thermal feedback monitors skin temperature and tracks temperature changes with a variable pitch tone. A thermister is attached to the hand, for example, and the individual is taught literally to warm his hand. The warming is accomplished by voluntarily increasing blood flow through vasodilation. Since peripheral vasodilation is a function of sympathetic arousal, any warming of the hands indicates lowered sympathetic arousal. This in turn indicates general relaxation which is another primary goal of biofeedback therapy. Simply learning to relax can benefit many individuals in many circumstances.

Thermal feedback also has specific applications, the

most notable of which is in control of migraine headache. Since the typical migraine headache is a product of initial vasoconstriction in the branches of the carotid arteries followed by a rebound overdilatation, any therapy is promising which teaches the individual to recognize and reverse the early signs of vasoconstriction. Migraine patients are taught to monitor their hand temperatures and to avoid allowing the hands to cool below 85 to 88 degrees. Normal hand temperature is usually about 92 degrees. Migraine patients typically have hand temperatures in the 70's. By teaching these individuals to warm their hands and thereby lower sympathetic arousal, excessive constriction in the carotid arteries can be prevented.

Another form of biofeedback is electroencephalographic (EEG) feedback. For purposes of biofeedback, the monitoring of EEG activity is restricted to 0-20 cycles per second in the cortex. Zero to three cylces per second is Delta which is characteristic of deep sleep. Four to seven cycles per second is Theta which is characteristic of light sleep or drowsiness. Eight to thirteen cycles per second is Alpha which is characteristic of an introspective meditative-like state. Fourteen to twenty cycles per second in Beta which is characteristic of wide awake and information-processing types of behavior. By monitoring EEG changes and translating these changes into simple tones, individuals can learn to shift voluntarily along the spectrum between Theta and Beta.

The most striking use of EEG feedback has been in the voluntary control of epileptic seizures. If the epileptic is taught to generate the sensory motor rhythm, the seizure can be blocked. Many cases have been reported in which the epileptic has successfully gained voluntary control over seizures and by doing so has been able to function totally without pharmaceutical help (Pelletier, 1977).

Advantages of Biofeedback

There are a number of advantages to biofeedback. One major advantage is that biofeedback is done by the patient rather than by the therapist. The patient learns to control himself rather than to be dependent on some other treatment. This aspect of biofeedback produces many important side effects in therapy. Individuals who learn voluntarily to cause their blood vessels to change in diameter are impressed with this skill and sometimes come to believe that if they can do that, they can do other useful things for themselves. This is preferable to being treated by someone else and therefore increasing feelings of dependency on the part of the patient.

Another important characteristic of biofeedback is its measurability. Since machines are constantly monitoring the exact physiological changes which the patient is learning to control, there is no doubt whether these changes take place. This allows scientific rigor to be introduced into this therapy and it is for this reason that biofeedback has been so heavily researched. Measurement is simply not feasible in many other therapies but is readily available to the biofeedback therapist with his biofeedback machine.

Summary

Biofeedback enters the 1980's as a viable, clinically useful therapy for certain well-defined pathological conditions. The rapid growth of this therapy, its general acceptance by the medical and psychological community, and recent decisions by some insurance companies to honor claims based on biofeedback therapy, indicate a promising future. Although many ailments are best treated with standard medical procedures, evidence supports biofeedback as a useful adjunct to traditional therapies. When the choice is between prolonged drug use and learned self-control, biofeedback is an appropriate alternative therapy.

References available from the author upon request.

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Behavioral Medicine — A Comprehensive View of Soma and Psyche

Arthur H. Rosen, M.D.

Medicine's traditional view emphasizes the distinction between mind and body and expresses this difference by contrasting functional and organic disease. During the 1930's and 1940's the psychosomatic school tried to bridge "psyche" and "soma" by offering a model that explained physical illness on the basis of unresolved intrapsychic conflict and offered cure with the resolution of this conflict.

Personality types were categorized and associated with a wide range of clinical illnesses such as ulcerative colitis, arthritis, and migraine headaches. Unfortunately, these personality types were descriptive of only a few patients who presented with these disorders. There are patients with migraine who are rigid, compulsive, and perfectionistic, but there are also many others who do not fit this mold.

Lipowski states that the failure of the psychoanalytic hypothesis led to great disenchantment with a psychosomatic approach. The psychosomatic approach no longer seems to be in the mainstream of medical thought.

The psychosomatic school tended to emphasize the intrapsychic aspects of the mind-body dichotomy. The dominant model, on the other hand, explains illness by emphasizing the biomedical nature of disease and considers the social, psychologic and behavioral variables of disease to be of secondary importance. Engel describes the classical scientific notion of the body as a machine and disease and physical breakdown of that machine; the doctor is described as one who repairs the machine. Despite the burgeoning advances in medical science, it is increasingly apparent that the individual's behavior largely determines health outcome. Whether an individual chooses to smoke, to eat excessively, to exercise, to drink, to comply with medical regimens, to eliminate stress overload, or to continue in a follow-up treatment plan are critical factors determined by emotional and psychosocial climates. Yet in our zeal to pursue the science of medicine, we have ignored or not appreciated, these considerations.

We can monitor virtually every body function and accurately measure substances in picograms, nevertheless, it seems that proper care of the patient requires a holistic approach that considers the relationship between mind, body, and behavior. Management dealing with the psychological care of the medically ill should also include assessment of the patient's intrapsychic, interpersonal, family, and occupational spheres.

Physical illness produces emotional stress. We have studied the effects on the critically ill patient of hospitalization in intensive care units. The acutely ill patient is deprived of normal sights, sounds, and diurnal rhythms in the ICU. Concomitantly he experiences overwhelming anxiety related to his life-threatening illness and to his dependence on a vast array of life-support systems. It is neither surprising that this area of the hospital has been referred to as the "Intensive Scare Unit" nor that many patients develop ICU psychoses.

Hackett and others have brought us new understandings of the need for psychological care of the patient in the coronary care unit. We recognize that the long-term prognosis for the post-myocardial infarction patient can be influenced by his psychological adjustment to the disease and by his ability to alter favorably unhealthy lifestyles.

We are more cognizant of the need for total care for burned patients, for the patients on dialysis, and for patients with spinal cord trauma. The work of Kubler-Ross and other thanatologists helps us to reconsider our proper roles as physicians. Now we consider caring for illness, albeit a fatal one, to be within the purview of medicine. No longer should we be satisfied only with curing a disease.

Caring concern is by no means a new approach in medicine. This approach is a pre-Flexnerian, Oslerian tradition of general medical care that has been largely carried on by primary care physicians. They focus on the patient's family and external circumstances and on internal aspects of disease. By selection and training the primary care physician tends to perceive the patient as a person rather than as a collection of individual organs, so the interplay between the psychological and the somatic health of the patient usually is apparent. Effective ways to study these dynamic factors are missing. We need to link psyche and soma and to be able to offer therapeutic opportunities for improving the effect of the mind on the body.

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This concept is called behavioral or stress medicine and attempts to integrate other disciplines into biomedical science for use in the prevention, treatment, and management of disease. Behavioral medicine draws on motivational research, communications theory, behavioral psychology, and it takes a rigorous scientific look at hypnotherapy, biofeedback, group therapy, and other stress management techniques.

Stress is both a physiologic and psychologic phenomenon. Stress may be perceived as an unpleasant emotional state, and stress-related illness results from adverse physiologic responses to stress. Behavioral medicine concerns itself with helping the individual to recognize and to modify these stressful patterns of everyday life, and, hopefully, to minimize their adverse effects on health.

Stress has been identified as environmental change requiring behavioral adjustment. Selye, a pioneer in stress research, describes the physiologic response to stress that is the final common pathway of diverse emotional reactions. Holmes and Rahe have developed a social readjustment rating scale (see Table 1) which suggests a direct relationship between the frequency and intensity of life change and the risk of associated stress related illness. The relationship ranges from 37 percent for subjects with scores of 150 to 199 life change units (LCU), 51 percent for subjects with scores of 200 to 299 LCU, to 79 percent for those with scores greater than 300 LCU. Personal injury or illness has a LCU value of 53 points. The patient with major illness then is at risk for development of secondary emotionally related physical problems.

Stress is related to many gastrointestinal, cardiovascular, and neuropsychiatric disturbances. Recent research supports the hypothesis that psychosocial factors modify host resistance to infection and neoplastic disease. This predisposition may be mediated through an immune system. A recent study demonstrates that T-cell function is significantly depressed after bereavement. Regarding sequelae to cardiovascular problems, Lown suggests that recent advances in neurochemistry and neurophysiology offer new opportunities to integrate beneficial effects on mind on body. Although the change from obesity to normal body weight is healthy, this change can be stressful. Ordinarily, the obese individual deals with stress by overeating, so the weight is regained.

Behavioral science teaches that human behavior is not fixed but is subject to change by a process called operant conditioning. A typical application has been the World Health Organization's successful application of behavioral science to improve the reporting and identification of new cases of smallpox. The most productive application of behavioral medicine helps the individual modify unhealthy lifestyles or behavior. I will discuss obesity as a prime example of the interplay of emotional

Table 1. — Social Readjustment Rating Scale*

Rank	Life Event	Mean Value
1	Death of spouse	100
2	Divorce	73
3	Marital separation	65
4	Jail term	63
5	Death of close family member	63
6	Personal injury or illness	53
7	Marriage	50
8	Fired at work	47
9	Marital reconciliation	45
10	Retirement	45
11	Change in health of family member	44
12	Pregnancy	40
13	Sex difficulties	39
14	Gain of new family member	39
15	Business adjustment	39
16	Change in financial state	38
17	Death of close friend	37
18	Change to different line of work	36
19	Change in number of arguments with spouse	35
20	Mortgage over $10,000	31
21	Foreclosure of mortgage or loan	30
22	Change in responsibilities at work	29
23	Son or daughter leaving home	29
24	Trouble with in-laws	29
25	Outstanding personal achievement	28
26	Wife begin or stop work	26
27	Begin or end school	26
28	Change in living conditions	25
29	Revision of personal habits	24
30	Trouble with boss	23
31	Change in work hours or conditions	20
32	Change in residence	20
33	Change in schools	20
34	Change in recreation	19
35	Change in church activities	19
36	Change in social activities	18
37	Mortgage or loan less than $10,000	17
38	Change in sleeping habits	16
39	Change in number of family get-togethers	15
40	Change in eating habits	15
41	Vacation	13
42	Christmas	12
43	Minor violations of the law	11

*From Holmes, T. H., and Rahe, R. H.: J. Psychosomat. Res. 11:213-218, 1967.

and physical factors in the etiology, pathogenesis, and treatment of an illness. A person's being overweight is an objective physical finding; obesity is more complex. Obesity is a constellation of physical findings having profound emotional, interpersonal, and socioeconomic effects. If one addresses only the physics of the problem, the first law of thermodynamics applies to the solution. If output of calories exceeds caloric input, weight loss occurs. That this approach is inadequate is attested to by the number of diet sheets that pass from doctor to wastebasket via the patient.

Few obesity problems are endocrinologic or genetic in origin, and few if any will respond to an approach that fails to consider the enormous emotional aspects of food and nurturing, as well as the profound emotional effects of being obese.

The work-up of the patient should include more than a complete physical examination and pertinent laboratory tests. It is often valuable to know the historical and sociological aspects of the patient's life. The age of onset, family history, and quality and types of interpersonal relationships offer insights into the etiology and treatments of the patients' problems. In addition to nutritional counseling and psychological support, a behavior modification program can be a useful therapeutic adjunct that may enable the patient to maintain an ideal body weight and to avoid the "yo-yo" phenomenon so commonplace in obesity.

Behavior therapy, or operant conditioning, relies on Pavlovian theories of learning and conditioned responses. This form of therapy looks at behaviors such as smoking, non-compliance, or overeating as being composed of several discrete behaviors determined or conditioned by stimuli that trigger the inappropriate response and by the reward or punishment nature of the consequences. A behavior that has numerous stimuli and immediate favorable consequences will tend to be perpetuated even if the long-term consequences are unhealthy. Cigarette smoking is triggered by a dozen or so daily experiences and by a relentless, effective barrage of advertising hype. Unfortunately, the immediate consequences of cigarette smoking are pleasurable and displace the influence of undesirable long-term consequences of chronic obstructive pulmonary disease and lung cancer.

Behavior can be modified by altering stimuli or consequences. This approach is called environmental planning and contingency management, respectively. An approach can be programmed to increase a desirable behavior such as exercise or to diminish an undesirable behavior such as snacking. Similarly, in other areas of health, desirable behaviors, such as compliance with drug regimens, pap smear testing, dental flossing, and cardiac rehabilitation, can be favorably influenced, and undesirable behaviors such as excessive alcohol intake or inappropriate salt consumption, can be diminished.

Chronic pain is a problem that has been resistant to most therapeutic regimens but can be helped through a behavioral approach. Frequently, pain, especially chronic pain, arises from nociceptive input. Pain is an experience with an emotional component and behavioral expression. The anticipation of pain can produce fear, depending on the patient's past experiences and current state of mind, whereas patients who are relaxed and prepared to experience pain tend to have less intra-operative problems and post-operative discomfort and fewer complications.

In many ways society positively reinforces pain and illness by giving days off from school, sick days at work, and disability checks. If a migraine headache entitles one to an afternoon off, the consequences positively reinforce the headache. In general, pain can be perpetuated by positive intrapsychic or interpersonal consequences, the so-called secondary gain. Euphoriant effects of the narcotic analgesics become a positive reinforcement for the pain.

Behavior modification might remove one habit only to create another. This concept seems logical enough; however, in actual practice, it is unusual that a sustained habit, if it develops, is as pernicious as the one it replaces. The former smoker may rely on chewing gum to satisfy oral needs, but it is a far less destructive practice to chew gum than to smoke.

For obese persons, overeating addresses more problems than hunger. Eating that is governed by the fine homeostatic mechanisms of the body machinery controls weight within a few pounds a year. It is when eating responds to needs other than hunger, such as depression, anxiety, fear, boredom, and anger, that overeating occurs. If obese individuals diet and modify their meal quantity, frequency, and type, they are deprived of this method of dealing with stress. Stress then must be met by alternative behaviors. The alcoholic, the drug abuser, or the workaholic must find other less destructive ways to cope with stress. Behavioral medicine helps patients to utilize self-hypnosis, relaxation response training, and biofeedback to achieve responses that are opposite to flight-or-fight responses that, in the chronic state, are so physiologically destructive.

This procedure has been called the relaxation response, and is largely determined by a parasympathetic state. Many persons can alter their muscle tone, respiratory and pulse rates, pain threshold, and other physiological responses through hypnosis. Hypnosis is not a panacea and should not be allowed to supplant an individual's responsibility consciously to direct his life. However, if hypnosis is incorporated in a comprehensive treatment plan, it can effectively augment a physician's therapeutic armamentarium.

In group therapy, persons with similar problems can

learn to change their lifestyles through the therapeutic employment of supportive group dynamics. This approach is the backbone of many groups that deal with alcoholism, drug abuse, and obesity. Behavioral physicians are utilizing this approach to deal with diabetics, person who have had myocardial infarctions and coronary by-passes, patients with arthritis, and persons with a vast array of other chronic illnesses. It is easy for patients to identify with others who have the same problem. They can share their hopes, their humor, and their frustrations. Group support enables the patient to comply with his own medical regimen.

The efficacy of group therapy is difficult to prove. Moos emphasizes that it is difficult to evaluate and to compare research findings in the behavioral sphere. Though more rigorously controlled double-blind studies are required to assess the specific contribution of group therapy in altering disease outcome, it is apparent that profound improvement in the quality of life can be achieved. Perhaps the disease itself and the mortality may be unaffected, but the illness, the subjective level of suffering, can be attenuated.

Many persons, not uncommonly obese patients, may benefit from assertiveness training in which they learn to express their needs actively and assertively, rather than with hostility or passive-aggressively. The obese patient may be expressing his anger at his spouse by stubbornly eating and defying the spouse's requests. sometimes this passive expression of anger is directed not at the spouse but at a parent or the physician. Through assertiveness training the patient can learn to express these feelings in less caloric ways. If some of these patterns are so deeply entrenched, the obese person may require family or marital therapy to resolve underlying conflicts.

Hypnosis can help persons to challenge and to change their self-image. The smoker has a certain image of himself when he smokes. Images are apparent when we examine the nature of cigarette advertising. A brand of cigarettes enables one to identify with a character type: the rugged individualist, the easy-going naturalist, the free thinker, the discriminating individual, the liberated woman, or the friendly chum. In this way smokers are "hypnotized" into feeling a certain way about themselves each time they light up. This can be a powerful reinforcement for smoking behavior. If the image is challenged through imagery rehearsal, more appropriate and less destructive behavior can result.

The "performance style" of the patient refers to methods individuals prefer to use and which have generally proven to be effective in dealing with environmental, situational, and interpersonal stresses. Further, if we want to motivate an individual, it is essential to allow him to employ his own style to effect the desired result. This approach is useful in dealing with individual patients and in helping health professionals, hospital personnel, and executives to deal with stress in themselves and those with whom they work.

The four performance styles are characterized by "Action," "Ability," "Analysis," and "Adaptation." Each of these has a strength, and each of these styles can become a liability.

The Action individual is motivated by the belief that if one acts quickly and decisively and takes advantage of opportunities then he can succeed in meeting his needs. The business tycoon or the entrepreneur typifies this character type.

The Ability person relies on his competence, perfectionism, and recognition of the needs of others to satisfy his own needs. Many health professionals fall into this category.

Those who prefer to have complete and thorough control over all variables before acting are described as Analysis types. The individuals in this category function quite competently in the research sciences, accounting, and law.

Those whose flexibility and sociability have been their greatest assets rely on Adaptation. These individuals do well in large organizational structures, particularly those that demand tact and flexibility.

Each of these styles is functional and is a method for dealing with stress. But each method becomes counterproductive when stressful events overwhelm the individual. The character strength becomes a weakness and the individual winds up spinning his wheels and becoming more distressed emotionally and physiologically. The Action person who has relied on decisiveness and leadership abilities becomes impulsive, gambling, arrogant, and over-controlling. The Type A personality described by Doctors Rosenmann and Friedman is typically the workaholic who suffers from "hurry-sickness" and a preoccupation with time urgency and competitive agressiveness. This coronary prone individual generally is an Action type and has great difficulty assuming the passive role of patient. These tend to be the patients who have the most difficulty accepting the regimen of the coronary care unit. Frequently they threaten to sign out against medical advice, or they violate hospital rules. This rebelliousness represents the perceived threat to the Action type's autonomy. The physician does better to allow this type patient to participate in the development of his medical regimen rather than to lock horns with him in a battle of wills. Certainly there must be non-negotiable demands that the physician must communicate to the patient, but the physician can enhance compliance through appropriate communication.

The physician must consider what kind of patient has a disease as well as what kind of disease the patient

has. For example, supplying more data and evidence about hazards of smoking would presumably have the greatest impact on the Analysis type. On the other hand, the Ability type would more likely be moved by the challenge and opportunity for self-improvement. The objective is not to change the performance style but to allow the individual to use it to his greatest advantage. One diabetic patient might be given encouragement to engage in a vigorous program of exercise (Action); another one would do better with instructions on exchange lists (Analysis).

Behavioral medicine has deepened the involvement of the physician with the patient and has broadened the view of illness. Behavioral medicine emphasizes the humanistic aspects of the doctor-patient relationship by incorporating the behavioral sciences. These hitherto unexplored modalities of patient management are being applied to many clinical situations. The same approaches are being used to manage stresses of health professionals. Hopefully, further study and application of these sciences in preventive and creative ways will decrease the disturbingly high incidence of "burn-out syndrome" among professionals.

These new approaches should not be incorporated only because they are different. They must be subjected to the same demanding criteria that are applied to other treatment modalities. They should not replace traditional medical management, but the behavioral sciences should be incorporated into the mainstream of modern medical practice.

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Dr. Joseph Matthews Is Vice Chairman Of Combined Blues Board

Joseph G. Matthews, M.D., of Orlando, former Chairman of the Board of Blue Shield of Florida, is the new Vice Chairman of the combined Blue Cross and Blue Shield of Florida, Inc., Board of Directors.

Dr. Matthews is one of seven physicians to serve on the new combined Board. Others are: Richard C. Clay, M.D., Miami; Irving Essrig, M.D., Tampa; Michael J. Foley, M.D., Melbourne; Charles P. Hayes, Jr., M.D., Jacksonville; Frank B. Hodnette, M.D., Pensacola; and Eugene G. Peek, Jr., M.D., Ocala.

Others on the 31-member Board represent hospitals and the public. G. Emerson Tully of Tallahassee, a public member, is Chairman.

Dr. Matthews and Dr. Clay will serve on the nine-member executive Committee.

Behavioral Sciences and Family Practice

Jacqueline Brower Orlando, Ph.D.
Shae Graham Kosch, Ph.D.

The integration of behavioral science and family medicine represents an important developmental task. Medical research supports the view that adequate diagnosis and treatment in primary care must include consideration of the patient in his broad psychosocial context. Increasingly, the family doctor treats illness and chronic problems which arise from and affect the patient's lifestyle, family, and community. Obesity, hypertension, headaches, functional syndromes, and substance abuse are seen with increasing frequency. The management of such conditions comprises a large segment of the family physician's practice.

Many family practice residency programs provide formalized education in psychosocial fields training, called behavioral sciences, and allow for space in the curriculum for teaching these subjects.

The Content of Behavioral Science Continues to Evolve

Frequently, psychiatrists, psychologists, anthropologists, and social workers are employed to teach the psychosocial sciences to family practice residents. These educators focus on the concepts of normal human development and psychopathology, interviewing and communications, and subjects each is best prepared to teach. Sheinvold, et al., identified high priorities in the curriculum as follows: 1) interviewing skills, 2) counseling techniques, 3) family dynamics and family therapy, 4) psychosomatic medicine, 5) doctor-patient relationships, 6) management of anxiety and depression, 7) substance abuse, and 8) adolescent psychology. These areas make up the essential core of most behavioral sciences programs in family medicine.

At the University of Florida/Alachua General Hospital Family Practice Residency Program in Gainesville, Florida, the perceived needs and previous training of the residents were measured with a questionnaire. The results allowed the curriculum to be tailored to meet the special preferences and needs of residents. In addition, periodic use of the questionnaire will allow for appropriate modifications to be made as background and perceived needs of the residents change. As a result of recent use of the questionnaire, the UF/AGH program now 1) includes value-clarification as it relates to medical decision making, as well as the high priorities described by Sheinvold, and 2) teaches a short course in practice management.

Approximately one-fourth of the educational conferences and seminars taught in the UF/AGH program give instruction in the psychosocial area as it relates to a family physician's practice. Lectures include such topics as behavior modification techniques, stress management, strategies to deal effectively with the difficult patient (i.e., the demanding, hostile, or sexually seductive patient), management of terminal illness and dying, adjustment to life crises (i.e., birth, divorce, retirement, menopause, workaholic syndrome, etc.), family therapy, sexual dysfunction, brief psychotherapy, counseling adolescents about drugs and sex, and other practical subjects. Lectures stimulate discussion of the information and how it can be applied to health care delivery.

How Bedside Manner Can Become An Acquired Skill

Most family doctors perceive themselves as humanistic, holistic individuals who have good interpersonal relationships. In the past, it was thought that you either got along well with people or you went into a specialty area that required little contact with patients. Residents now are exposed to a system of learning that enhances their skills for accurate listening and effective communication. Residents are often surprised to learn that they do not apply human relations skills as effectively or systematically as they could because they have not been taught to do so. To them skill development means such things as interpretation of EKG's, palpation of an organ or listening to a heart, not the phrasing of a question or interpretation of a non-verbal gesture.

Sometimes residents who are struggling with the pressures of a residency program hesitate to look at their

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own behavior. For many residents at this level of professional training, such goals as self-awareness or learning to read body language seems threatening or unimportant. Realizing this, Kagan designed an approach to teaching interpersonal skills that eliminates the physician's defensiveness and places him in charge of his own learning process. Through the use of systematized instruction and video-technology, the resident is able to replay a real or simulated doctor-patient encounter and to identify behaviors that contribute to building effective relationships.

Through study of the self-in-action, the resident is able to improve his skills in recognition and control of complex interpersonal relationships. This approach to teaching is Interpersonal Process Recall (IPR) and forms the groundwork of a widely used supervision model.

How Can the Physician in Practice Improve His Own Interpersonal Skills?

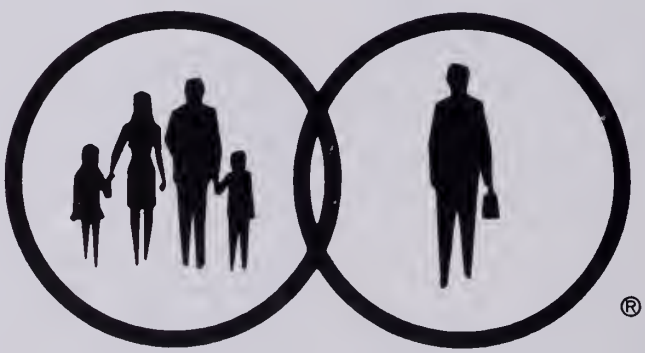
Many physicians continue to enhance their interpersonal skills after leaving residency programs. This can be done in several ways. Patients can provide feedback that allows the physician to know where his interpersonal strengths and weaknesses lie. A tactful nurse or receptionist can gather valuable information in an unobtrusive manner regarding patients' reactions to the physician. Sometimes a trusted colleague will discuss his friend's professional style in a straightforward manner.

> For example, Doctor Brown might learn that he is seen by his patients as cold, disinterested, or hurried. His professional partner indicates that other doctors find him difficult to relate to and view him with suspicion. With his nurse and/or partner, he determines which behaviors contribute to this impression. He learns that more eye-contact, a friendlier opening, and increased attention to the patient's worries and concerns will help him appear warmer and more trustworthy. With this knowledge, the physician will be able to become a more effective physician.

A large amount of medical literature deals with doctor-patient relationships. Continuing medical education programs provide instruction in techniques to improve data gathering, medical problem-solving, and compliance problems. Once an individual recognizes that he needs to pay attention to how he deals with others, he can rapidly improve his practice skills.

References are available from the author upon request.

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Primary Care in Plastic Surgery

Samuel G. Rosenthal, M.D.

Abstract: Family physicians enjoy a unique relationship with patients, and they should form the keystone of the patient-plastic surgeon interaction. Specific recommendations for plastic surgery attention are discussed. Prompt plastic surgery consultation is appropriate for any patient with a congenital anomaly. General care for burn wounds and the specific problem of lye burns are discussed. Hypertrophic scars can be treated with cortisone impregnated tape or with injection therapy. Some of the relative contra-indications for aesthetic surgery are discussed as well as a highlighting of the indications for subcutaneous mastectomy and general breast reconstruction.

This presentation is a brief outline for primary care physicians. It is hoped that it will serve to direct proper plastic surgical consultations and briefly update what is currently available to your patients from some of your plastic surgery colleagues.

The thrust of the following review should further acquaint the family physician with plastic surgical practices and in a general way what is involved. It is hoped that once the advances in the field are recognized, the natural restriction of many of our practices will be understood. Proper referrals, based on our understanding of who does what, will reflect well on us all. The breadth of the speciality can be best presented by a review of its own defined areas of activity. I shall highlight each area's content, newer techniques, and areas of progress.

Congenital Anomalies

I appreciate the opportunity to consult with the parents shortly after birth. In seeing the parents of the newborn with a cleft lip, for example, the plastic surgeon is best able to define goals and answer the concerned parents' questions. A general discussion of corrective surgery is quite encouraging to them during this trying period. Prompt coordination of a treatment plan solidifies family/family practitioner/plastic surgical rapport. Usually cleft lip repairs are performed when the baby has gained to 10 pounds (approximately 10 weeks.) Cleft of the soft palate is repaired at one to one and a half years of age, and repairs of the hard palatal clefts are done two to around three years of age. Coordination with other surgical specialists, dentists, and speech personnel are handled by the plastic surgeon.

Excisions of giant hairy nevi are best performed in early infancy since the laxity of skin allows rather aggressive excisions and reconstructions.

Craniofacial deformities, hypospadius, hemangiomata, and lymphangiomata all warrant early consultation, if just to reassure the parents about current practices. Proper gender assignment for the child born with ambiguous genitalia should be undertaken during the early days of life. Circumcision should specifically be avoided!

Burns — Care of Minor Burns

Minor burns include superficial (first degree), and partial thickness (second degree) burns of less than 15 per cent of body surface area.

The superficial burn requires analgesia for the first few days and then antipruritic therapy. I prefer Doxycycline Hyclate 50 mg by mouth every four hours as needed for the itching.

Blisters of second degree burns should be left alone. Gentle cleansing of the wound and application of a nonadherent gauze-bulky dressing, changing it every three or four days, is appropriate. For torso burns, Silver Sulfadiazine cream applied twice daily is appropriate. Prophylaxis against tetnus is proper.

Sleep-wear ignition is the most common single cause of serious pediatric burns. Concern over possible carcinogenicity of tris phosphate, a flame retardant agent, has dampened progress in this area. The two most common ignition sources for nightwear are stoves and matches. Patient education in this area is so very important.

Lye Burns

If there is suspicion of contact with lye, the patient should be placed immediately in a shower, and if the facial area is involved, immediate consultation with an ophthamologist might salvage an otherwise dismal outcome. It is here that the primary care physician can function effectively to minimize morbidity. Immediate, continuous body and/or ocular irrigation can abort the progressive damage of the lye burn. Irrigation must be continued for approximately 24 hours.

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Trauma

Simple linear lacerations can be repaired well by physicians disposed to using the finest sutures capable of coapting, without tension, the wound margins. I generally favor 5-0 to 6-0 nonabsorbable suture (silk or nylon) for repair of facial wounds and 4-0 to 5-0 nylon on extremity and torso wounds. A few absorbable sutures should be placed subcutaneously to diminish skin wound tension. I prefer Vicryl 5-0 on the face and 4-0 on the extremities. With patience, most physicians can repair linear wounds and are quite gratified with their efforts. Should the need arise, plastic surgical repair can be undertaken electively, when the patient is more fully cognizant of the goals and limitations of speciality surgery.

Hands

Hand surgery is extremely complex and requires special expertise. Incredible advances in microsurgery have made possible the salvage of countless digits and other portions of the extremities. It, therefore, is incumbent on us all to be aware of where the nearest replantation surgery can be performed.

Maxillofacial Surgery

Deformities of the face whether post-traumatic, post-surgical, or of a congenital nature, gave birth to the speciality of plastic surgery. The myriad of reconstructive problems will not be discussed. Plastic surgeons are fundamentally grounded in reconstruction of the head and neck. Their basic education and training is the marriage of surgical techniques and aesthetics.

This is realized, for obvious reasons, most appropriately in surgery of the head and neck. Modern plastic surgery began here with the treatment of war injuries of the face in World War I and continues to this day.

Surgery of the Integument

Skin cancer is treated by many medical practitioners. In general, basal and squamous carcinomata of a size and/or location that requires excision in an operating room might best be referred for plastic surgical attention. This would exclude the vast majority of early lesions which are so ably managed by dermatologists by curetage and cautery. A large part of plastic surgeons' skin care practice is referred by dermatologists for treatment of larger lesions, lesions in difficult locations (eyelid, nose, ear) and for recurrent lesions. Plastic surgeons, on the other hand, refer recalcitrant lesions to chemosurgeons and radiotherapists. The primary treatment of a melanoma is a wound problem. Melanomas are frequently treated by plastic surgeons or in concert with general surgeons. Immunotherapy consultation is not unusual early in the course of treatment.

Keloids continue to be a theraputic dilemma. Serial intra-lesional injections with Kenalog-10 every three weeks seems most effective. Puritis responds quite dramatically. For more resistant lesions, excision with steroid use intraoperatively, with or without immediate post-operative radiotherapy, is used by some.

Cordran tape applied nightly is a pleasant treatment for hypertrophic scars. It is quite safe and coupled with the passage of time, quite effective. Therapy continues for months in many cases.

Aesthetic Surgery

In this much publicized area, I prefer to discuss the contraindications rather than the more obvious indications for surgery. At the close of most lay articles on the subject is an exhortation to the reader to check with his or her personal physician. As a plastic surgeon who devotes the bulk of his time to aesthetic surgery I would share the following advice with you. The gravest and most common error in aesthetic surgery is poor patient selection. We have all had the misfortune to operate on persons with troublesome personalities. Some of the following signals should caution against cosmetic surgery. Unrealistic expectations leads the list of undesirable factors. Perfectionists, patients who magnify minimal deformities, indecisive patients, or patients driven to surgery by friend or family, tend to be troublesome. Bad results might also accrue patients suffering recent emotional trauma such as loss of a loved one or loss of an important position. The above circumstances should alert the referring physician that delay or abandonment of cosmetic surgery might be prudent. Unfortunately, many patients are quite adept at hiding their unrealistic motivations especially if they find that a given trait will disqualify them as candidates for surgery. It is in this area of proper patient selection that input from the family physician is invaluable. No physician is more apt to cancel surgery than an aesthetic surgeon. We try to tune in to our patients and to be as sure as we can that they will be receptive to our efforts.

There are two rapidly growing areas of plastic surgery that should be of particular interest to family physicians. These patients are women requesting information about subcutaneous mastectomies and breast reconstruction after cancer surgery. This work occupies an increasing percentage of my practice time.

A subcutaneous mastectomy is the removal of approximately 95% of breast tissue with the preservation of the overlying skin, nipple, and areola. Reconstruction with a mammary prosthesis may be delayed four to six months, however, some surgeons prefer immediate reconstruction.

Indications for subcutaneous mastectomy include chronic cystic mastitis, repeated breast biopsies, mastodynia that is resistant to conservative measures and other breast problems. Lobular carcinoma in situ and high risk breasts such as the contralateral breast in a

patient with breast carcinoma and a strong family history of breast cancer may be indications. The most common indication for this operation in my practice is fibrocystic disease coupled with cancerphobia. Recognizing that breasts have little functional use but have significant cancer risk coupled with the nodular breasts and limitations, and even risk of repeat mammography, some women prefer the risks of surgery to a lifelong vigil of lump follow-up and repeat X-rays. It is hoped that patients will enjoy a better quality of life without this overriding fear of breast cancer. No assurance that breast cancer is obviated by this procedure is given, but the nature of the surgery is such that the pre-operative breast cancer concern abates. Awaiting the second stage re-inforces the patient that she does indeed have little cause for concern (with the gross absence of the breast glands) and comes to reconstruction with more safety and emotional strength. It is certainly appropriate that the physician most sensitive to the emotional needs of his patient be the one who first mentions this alternate to his patient. He may be quite pleasantly surprised at the sometimes exuberant acceptance of this proposal by the beleaguered patient.

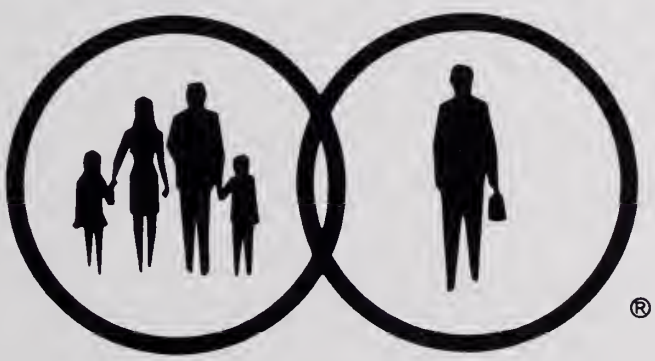
Breast reconstruction after ablative breast surgery has lately received great acclaim. The trend of our general surgical colleagues to perform modified radical mastectomies over the last few years has generated more surgical candidates for reconstruction. One recent estimate placed the number of modified radical mastectomies at 80% of mastectomies done in our area. The preservation of the pectoralis major muscle has made surgical reconstruction of the ablated breast a more easily performed plastic surgical technique. The patient with a modified radical mastectomy can look forward to a more acceptable aesthetic result. Usually surgery can be performed, on an out-patient basis, four to six months after mastectomy. Some men urge immediate reconstruction.

Since surgery for breast cancer may not require mutilation, women should not delay seeking physician consultation for possible breast carcinoma. Reconstruction of nipple and areola, though elected by few satisfied patients, can be performed approximately six months after reconstruction of the breast.

Conclusions

Family physicians enjoy a unique relationship with their patients. It is in this relationship of trust and understanding that one can properly select those patients who are candidates for plastic surgery. It is hoped that this review, including personal reflections by the author, will help guide the family physician in caring for his patients. Continuing communication between physicians is perhaps the best assurance of delivery of sensitive, sensible, and high quality medical care.

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Obstetrics in Family Practice: One Man's Relationships

Kenneth Kiehl, M.D.

My practice experience with colleagues in obstetrics and pediatrics began with military days in the United States Army. After a rotating internship in a civilian hospital I spent two more years in a military general practice residency. Then I was sent to Ft. Benning, Georgia.

I had the opportunity to select duty in obstetrics and gynecology. My next two years were spent delivering babies, doing minor obstetrical surgical procedures, and assisting in emergency obstetrical and gynecological surgery.

After my military tour of duty, I hastened to set up practice in Sarasota where opportunities were plentiful for family physicians. I was especially attracted to this Florida city because I could do obstetrics. Several other general physicians and I shared OB responsibilities with five obstetricians.

I attend monthly meetings of the Department of Obstetrics and Gynecology at my hospital; I have voting privileges; and I helped to set up the OB floor and recovery room and to establish delivery room policies.

This sharing in the work of another specialty department provides quick access to consultation with my colleagues when OB problems arise. Often, since we know each other well, consultation consists of a brief visit, review of the problem, and reassurance by the consultant that patient management is proper. Breach presentations, difficult forceps deliveries, prolonged labor, premature rupture of membranes, and OB patients with complicating conditions such as diabetes, preeclampsia, and heart disease are managed more effectively with the knowledgeable and friendly collaboration of obstetrical colleagues.

Because of my close association with colleagues in other specialties my competencies have increased and my interest in obstetrics has continued. I recommend to young family physicians the inclusion of OB in their practices. I abhor petty jealousies among specialists and commend the spirit of cooperation I perceive as family practice assumes its proper place in the delivery of health care to Florida's citizens.

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Thirty-Nine Years of Family Practice

Walter W. Sackett Jr., M.D.

Thirty-nine years of family practice brings to mind more than a host of respiratory infections, gastrointestinal disorders, injuries, and other medical problems large and small. I think of the 6,500 babies I delivered, some with complications such as Bandl's ring. I think of the 500 blood transfusions I gave to each of two Chinese children with Thalassemia major. I remember emergency Cesarean sections, myocardial infarctions, strokes, cancer . . .

One of the more memorable events in my medical life began with a little boy I delivered in 1948. We soon found that he could not retain his feedings, not even water. X-ray examinations revealed a complete obstruction at the duodenum. In those days studies were performed slowly, and three weeks later this patient's weight had dropped from 7½ to 5½ pounds. The baby was kept alive with subcutaneous fluids and several small blood transfusions.

I performed a gastroenterostomy. The duodenum seemed to be a solid mass. My associate believed we were dealing with a malignant tumor.

Soon after we completed the operation the baby was able to take liquids and then more substantial foods. He did quite well even though the radiologist said the stoma was not adequate.

In a month the mother brought the baby and his twin sister to the office. The only differences in the children were the surgical scar and the physical features peculiar to their sex.

After a few years I lost contact with the patient. But in 1977, 29 years later, I again admitted to the hospital the twin on whom I had operated for complete duodenal obstruction. He had been flown to Florida from Zaire where he was working and had sustained fractures of the tibia and fibula. After his fractures were attended to, I ordered an upper gastrointestinal series. The radiologist reported: "Gastroenterostomy which is the only functioning route of the barium to leave the stomach. Massively dilated first and second portions of the duodenal loop which apparently make up a blind pouch containing much retained secretions and which eventually fills with barium." Surgeons whom I consulted assured me that no further treatment of the intestinal tract was necessary.

Remarkably, this patient also had a congenital cataract with complete loss of vision in one eye. He is a surveyor and seems not to be handicapped by his visual impairment.

In this day of medical sophistication, I stand amazed that this baby survived. His survival suggests, though, that we probably didn't practice such bad medicine in those bygone days.

The Author

WALTER W. SACKETT JR., M.D.

Dr. Sackett is past president of the Florida Academy of Family Physicians and past vice president of the American Academy of Family Physicians. He is in private family practice in Miami.

• Dr. Sackett, 2500 Coral Way, Miami 33145.

Care of the Aged

H. L. Harrell Sr., M.D.

The Florida Governor's Council on Aging is in the process of developing policies on care of the aged. Preparations are being made for an annual conference to be held in September 1980 in Orlando and for the President's Conference to be held in Washington in 1981. This article reports problems of interest to the medical and allied medical professions.

It is a matter of concern that medical schools teach little about geriatrics. Geriatrics belongs to all specialties. Degenerative diseases concern all physicians, particularly surgeons, internists, and family physicians, and to a large extent the more narrowly based specialists, cardiologists, neurologists, neurosurgeons, psychiatrists, oncologists, and gynecologists. Vascular surgeons are especially involved in caring for many occlusive circulatory diseases commonly found in aging patients. Early recognition and appropriate management of vascular deficiencies can decrease morbidity.

Making a medical specialty out of an age related segment of our population has presented problems. Pediatricians still bicker over whether their cutoff age is at puberty or young adulthood. Pediatrics has faltered the last few years and has become less attractive to medical school graduates. A new specialty of geriatrics will suffer the same fate. The fact that the older age group is increasing in numbers does not justify a separate specialty. A geriatrics specialty would not contribute to the scientific practice of medicine. Further fragmentation of medical care is unnecessary and would be more expensive.

The medical profession likes to think it is responsible for the country's geriatric problems. In my lifetime predicted longevity has increased 30 years, making for an enormous increase in the number of older people. We physicians feel that it is also our responsibility to solve the health problems of the elderly.

You have probably heard of the three states of motility of humans: 4 legs (crawling), two legs (walking), and three legs (walking with a cane or other support). To these stages I would add on each end a helpless stage. (Fig. 1.)

Figure 1

No Legs	4 Legs	2 Legs	3 Legs	No Legs
Helpless	Crawling	Walking	With Cane or Walker	Helpless
6 Months	6 Months	71 Years	3-6 Years	6 Months to 20 Years

The first six months do not present insurmountable problems, but the second helpless stage presents many difficulties. Many civilizations, such as the Chinese, had enough reverence for old age to nourish the elderly carefully and lovingly. Primitive civilizations, such as the American Indian, respected and protected their aged. Our medical expertise has insured that other than the fittest survive to ripe old age. During the first helpless stage of development we have few problems because of protective parental instincts. The second helpless stage frequently taxes family resources even though the elderly family members are loved and respected.

The interests of the aged should coincide with the interests of younger people. Grandfathers and grandmothers should be interested in our country's economy, morals, and leadership. They can be as active in directing local and national issues as the younger people are, and in many instances they have enough prestige, well-budgeted time, and executive ability to be more effective. It is their duty to try to help restore to the American people pride and enjoyment in work.

We must continue to utilize the experience of the elderly, to remove the restrictions of social security and minimum wage laws, and to allow them work, even for small wages or in voluntary services. Adjustment to old age is largely related to continued employment of some kind.

Housing and food for the elderly are related to medical care. We may be deficient in providing certain levels of home health care, nursing homes, and intermediate care facilities, but we can be proud of housing developments with step-down condominiums appearing

The Author

HENRY L. HARRELL SR., M.D.

Dr. Harrell is a past president of the Florida Academy of Family Physicians and is in private family practice in Ocala.

throughout the state. Funding of nursing homes continues to be a problem. Some better mechanism must be found to supplement Medicare and Medicaid programs.

Meals-on-Wheels and conjugate dining are valuable assets to nutrition of the elderly. Volunteer workers with these programs show that there can be cooperation between concerned people and bureaucratic agencies.

The medical profession is diligent in trying to control the spiraling costs of medical care for the aged. I'm convinced that the federal government is not efficient enough to pay for the medical care of social security recipients. The increasing inadequacies of Medicare and Medicaid are examples of inefficiencies. We must return to local unit indigent care to give needed tax support to hospitals or nursing homes. Even then, management of city and county hospitals should be left to private enterprise, which is really the acme of efficiency.

Physicians might reduce their fees for patients over 65 who are dependent on inadequate retirement incomes. With our burgeoning retirement colonies in Florida, physicians can make good incomes on volume. Groups of physicians giving primary care help to reduce cost. Such centers are being started in many areas of the United States.

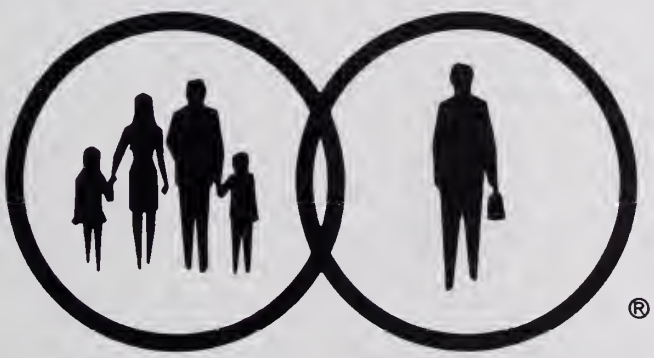
Older people are being exploited by insurance companies. Increasing insecurity makes them vulnerable to the blandishments of agents selling practically worthless health insurance which the elderly can ill afford. Dwindling incomes in the face of inflation make catastrophic illness a calamity. Frantic fear makes a fertile field for exploitation. Some organizations of elderly people have allowed themselves to be promoters for enticing brochures on health insurance which almost amount to mail fraud.

Conclusions

There are and will continue to be problems in adequate medical care and social adjustment for the aged population in Florida. This group provides significant contributions to the economy of the state. Floridians should have no difficulty in understanding why retired persons want to come to Heaven before they die. We really do enjoy sharing our remarkable climate with our less fortunate northern neighbors.

References available from the author upon request.

● Dr. Harrell, 1433 S.W. 1st Avenue, Suite 1, Ocala 32670.



Medicine in the Florida Keys

H. K. Moore, M.D.

The fabulous Florida Keys are unique. This string of islands stretches a hundred miles southwesterly from the mainland. Tourists are treated to the sight of natural formations zealously guarded by environmentalists. These features that attract so many visitors also cause problems for those of us who practice medicine in Monroe County.

There are four hospitals on the Keys. Attendance at medical meetings can be difficult. Meeting sites have to be alternated. A unified medical society, vital for solving our problems and furthering meaningful continuing education is a dream. Doctors in Key West and Key Largo, 90 miles apart are virtual strangers.

Access to continuing medical education is a special problem. In many other areas physicians can attend seminars at night and qualify easily for their required 50 hours a year of approved postgraduate education. Elsewhere there are state and regional meetings close at hand. Those of us in Key West cannot even go to Miami for a meeting without hardship. To drive or fly 150 miles to Miami is expensive, troublesome, and interrupts our medical practices.

When I opened my office in Key West in 1946, there were only five civilian physicians here. There were no doctors between city limits of Key West and Florida City, 130 miles away. There were no hospitals between Key West and Homestead. It takes little imagination to picture the overwhelming problems that faced an overworked medical profession. Even though there are now over 50 members of the medical society, all of our problems are not yet solved.

The practice of medicine in the Florida Keys has its advantages. Where else do you have our tropical climate, our excellent fishing, our clear water, our beautiful reefs, and our unique facilities for scuba diving? These advantages are offset, however, by our isolation from specialists and special diagnostic and therapeutic procedures, problems of transportation of seriously ill patients, and the aforementioned difficulties in pursuing continuing education.

My thoughts as presented here are not to be considered despondent. We are constantly striving to improve the quality of medical care in the Keys. We are actively dealing with physicians who misuse drugs. We cooperate with the Dade-Monroe PSRO. We constantly encourage continuing medical education among our peers.

Medical practice in the Florida Keys will always pose problems alien to other medical societies. All we ask is understanding from our colleagues on the mainland as we wrestle with our particular problems. The pioneer spirit of Keys' physicians will prevail.

The Author

HERMAN K. MOORE, M.D.

Dr. Moore is a family physician in private practice in Key West.

● Dr. Moore, 600 Elizabeth Street, Key West 33040.

The 1980's: National Issues and Florida's Physicians

Walter W. Lane, M.D.

The 1950's and early 1960's heralded great achievements in research and marked many scientific breakthroughs. The late 1960's and 1970's placed emphasis on delivering the promises of the technological advances of the earlier decade.

Many changes have occurred and are represented by Hill-Burton hospitals, soaring medical school enrollments, Medicare, Medicaid, intensive care units, and renal dialysis programs. The country has been on a shopping spree, and now the bills must be paid. The 1980's will be a decade of change and possible hardship for physicians. Awareness and careful planning is vital for the well-being of all.

To face the future effectively we must avoid fighting yesterday's battles. Physicians in organized medicine in Florida seem not to have learned that National Health Insurance (NHI) is dead. NHI was originally presented as a means of providing access to medical care for the poor. The public knows this has been accomplished. Harry Swartz in an article in the *Wall Street Journal* (February 1980) points out that the poor now receive more health care of all types than do the middle and upper income groups. Even politicians know the promise of access to health care is not an effective vote buying gimmick.

Through our medical organizations we should not waste effort on the issue of improved access to health care. This battle has been won.

Side issues such as catastrophic insurance coverage, payment for permanent long-term disability, and support for geriatric disability remain to be resolved. The problem is financial. Who will pay the bills and how much? There is no ground swell of public support for a major change in our health care delivery system on these issues.

National health insurance is still discussed, but the meaning is different now. NHI no longer means massive health care provision programs; but now it means cost containment, rationing of health care, free controls, and technological restraints. The threat of socialized medicine is still a reality. If we are to avoid socialized medicine, we must resolve the issue capable of generating major health care changes in the 1980's, that is the fixed health dollar.

The Author

WALTER W. LANE, M.D.

Dr. Lane is a family physician in private practice in Tampa.

In the 1960's and 1970's change was generated by a blank check approach. Given enough dollars medicine could do anything. Billions were spent on research, new medical schools, hospitals, and new technology. This has come to an end. Society cannot afford to spend an infinite amount of money to save a single individual. The philosophy that we physicians hold that human life is worth any amount of money is not held by the taxpayer who is footing the bill. If we do not face the issue of medical economics squarely, there will be a major restructuring of health care delivery.

The fixed medical dollar holds great significance for Florida's practicing physicians. These physicians compete for the same dollars with hospitals, laboratories, equipment manufacturers, pharmaceutical firms, insurance company administrators, and nursing homes. While physicians are frequently commercially naive, hospitals, nursing homes, and manufacturers are very much aware that a dollar spent elsewhere is a direct loss to them. Health costs must be controlled. Will Florida's practicing physicians receive a fair share of fixed medical dollars?

In the May 1979 issue of *Time* Magazine an article entitled "Those Expensive New Toys" questioned the nation's ability to pay for CAT scans and electronic fetal monitors and further questioned the cost effectiveness of coronary by-pass surgery and renal dialysis programs. Coronary by-pass operations in 1978 were cited as costing from $10,000 to $15,000 each; 80,000 were performed. This procedure remains controversial without clearly demonstrating a decrease in mortality. The renal dialysis program in 1978 covered 44,000 patients at a cost of one billion dollars, an average cost of more than $25,000 for one year of less than high quality life. This article is but one of many reflecting a growing realization that technical restraint must be a mandatory function of successful medical cost control.

Society's decision to limit health care expenses forces the medical profession to develop and implement logical bases for rationing health care delivery.

Physicians must serve Florida's citizens effectively by providing the best possible care in the most cost effective manner. Can Florida's physicians fulfill these economic and health care needs? The primary providers of health care, the practicing physicians, face a challenge ing decade in the history of medicine.

● Dr. Lane, 11212 North Dale Mabry, Tampa 33618.

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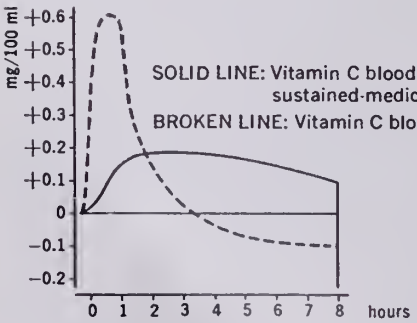
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*Comparison of ascorbic acid blood levels after administration of 1 gram of ascorbic acid in effervescent tablet form and 1 gram of CEVI-BID (2 capsules). *Adaptation

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1. Riccitelli, M.L.: Vitamin C Therapy in Geriatric Practice, J. Amer. Geriatrics Soc. 20:34, 197
2. Riccitelli, M.L.: Vitamin C—A Review. Conn. Med. 39:609, 1975

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Causes and Prevention of Medical Malpractice Claims

James W. Walker, M.D.

In the May 1979 issue of *The Journal of the Florida Medical Association*, the 10 leading causes of malpractice claims were reported for the FMA's sponsored plans for the years 1963-1978. The claims, which now exceed 9,000, and the losses, which amount to well over $100,000,000, have been divided into 21 categories. This report will update the loss experience as to claims frequency and severity through 1979 for the 10 leading causes.

Frequency

There have been minor changes in the classifications as to frequency. Foreign body left in patient during surgery is now ranked number six. Injury from falls is now in the number seven position. Significant is the appearance of error of an employee as number 10.

Severity

The trend that was reported last year as to awards in cases resulting from injury to mother in childbirth has continued. This now ranks number one as to severity of claims received. Improper anesthesiology is now ranked second and injury to child in childbirth is now third. As reported last year, these three did not appear in the top 10 as to severity just a few years ago. Significant also is the fact that lack of proper informed consent for surgery is now number seven as to severity, and assault (generally, operating without prior permission) is appearing for the first time as number 10.

These significant changes should sound an alarm to all physicians to thoroughly document informed consent and make sure that it is properly witnessed and signed.

The Author

JAMES W. WALKER, M.D.

Dr. Walker is President of Professional Insurance Management Company (PIMCO), and Physician Insurers Association of America.

Ten Leading Malpractice Causes
(Florida Medical Association's Sponsored Plans 1963-1979)

Frequency

1. Improper diagnosis (not involving surgery)
2. Technical surgical error
3. Adverse reactions to drugs
4. Improper treatment of fractures
5. Improper anesthesiology
6. Foreign body left in patient during surgery
7. Injury from falls (during examination or while under doctor's care)
8. Injury to child in childbirth
9. Infection in surgical site
10. Employee error

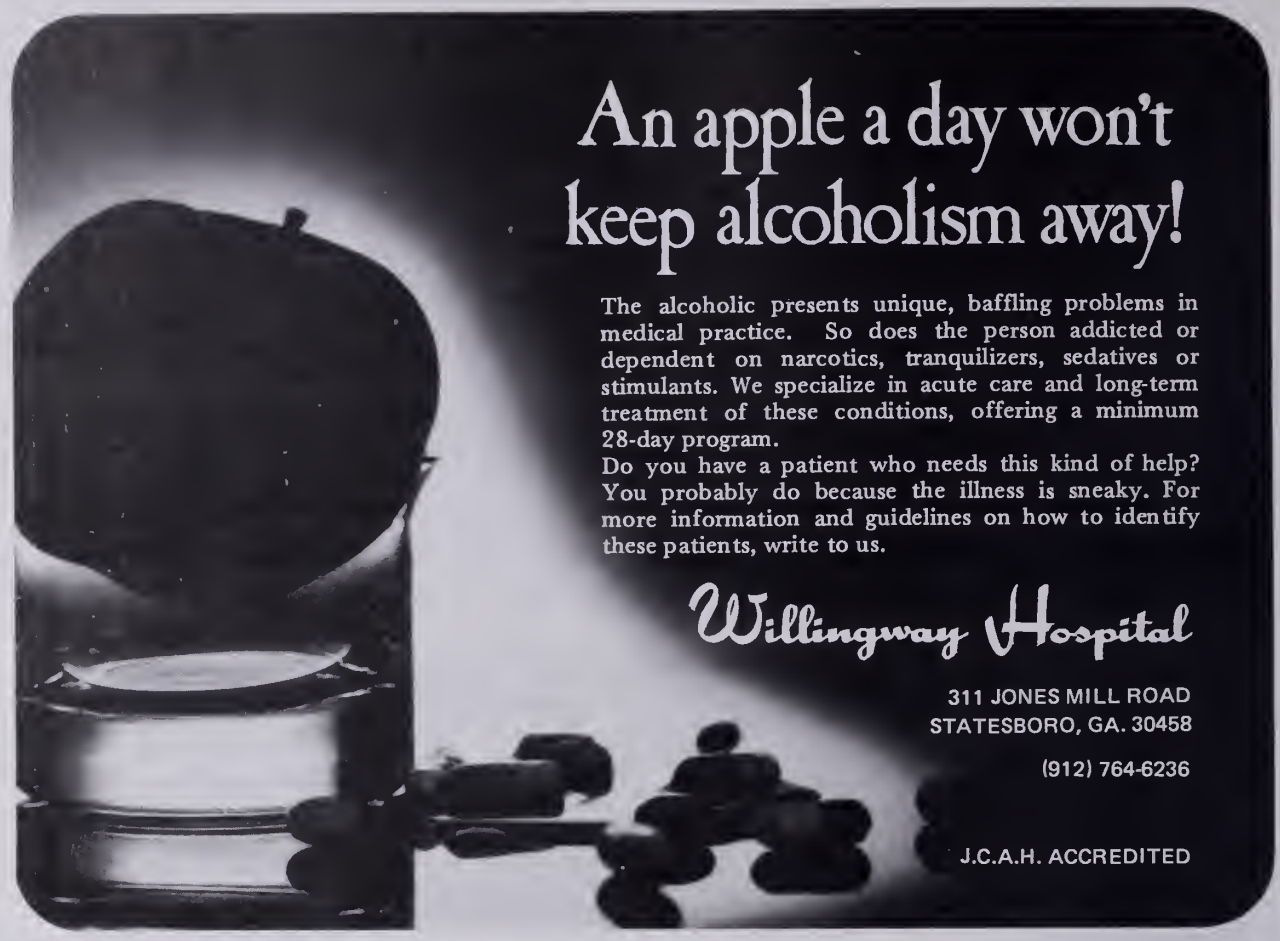
Severity

1. Injury to mother in childbirth
2. Improper anesthesiology
3. Injury to child in childbirth
4. Technical surgical error
5. Improper diagnosis (not involving surgery)
6. Infection in surgical site
7. Lack of informed consent
8. Adverse reaction to drugs
9. Disfigurement from surgery
10. Assault (generally, operating without prior permission)

The need for obstetricians, anesthesiologists, and pediatricians to document thoroughly those procedures in which they become involved is likewise noted.

Most of the claims which we are receiving are preventable and thus, there will be renewed activity on behalf of the Florida Physicians' Insurance Reciprocal in the area of loss prevention. The premiums each of us must pay for professional liability insurance will ultimately be determined by how successful we are in claims prevention.

• Dr. Walker, 1000 Riverside Avenue, Jacksonville 32204.



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The alcoholic presents unique, baffling problems in medical practice. So does the person addicted or dependent on narcotics, tranquilizers, sedatives or stimulants. We specialize in acute care and long-term treatment of these conditions, offering a minimum 28-day program.

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Indications: As an aid in the management of decubitus ulcers.

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Contraindications: Known hypersensitivity to any of the ingredients.

Adverse Reactions: Gastroenteritis and renal irritation have been reported following percutaneous absorption over a massive area.

Caution: Federal law prohibits dispensing without prescription.

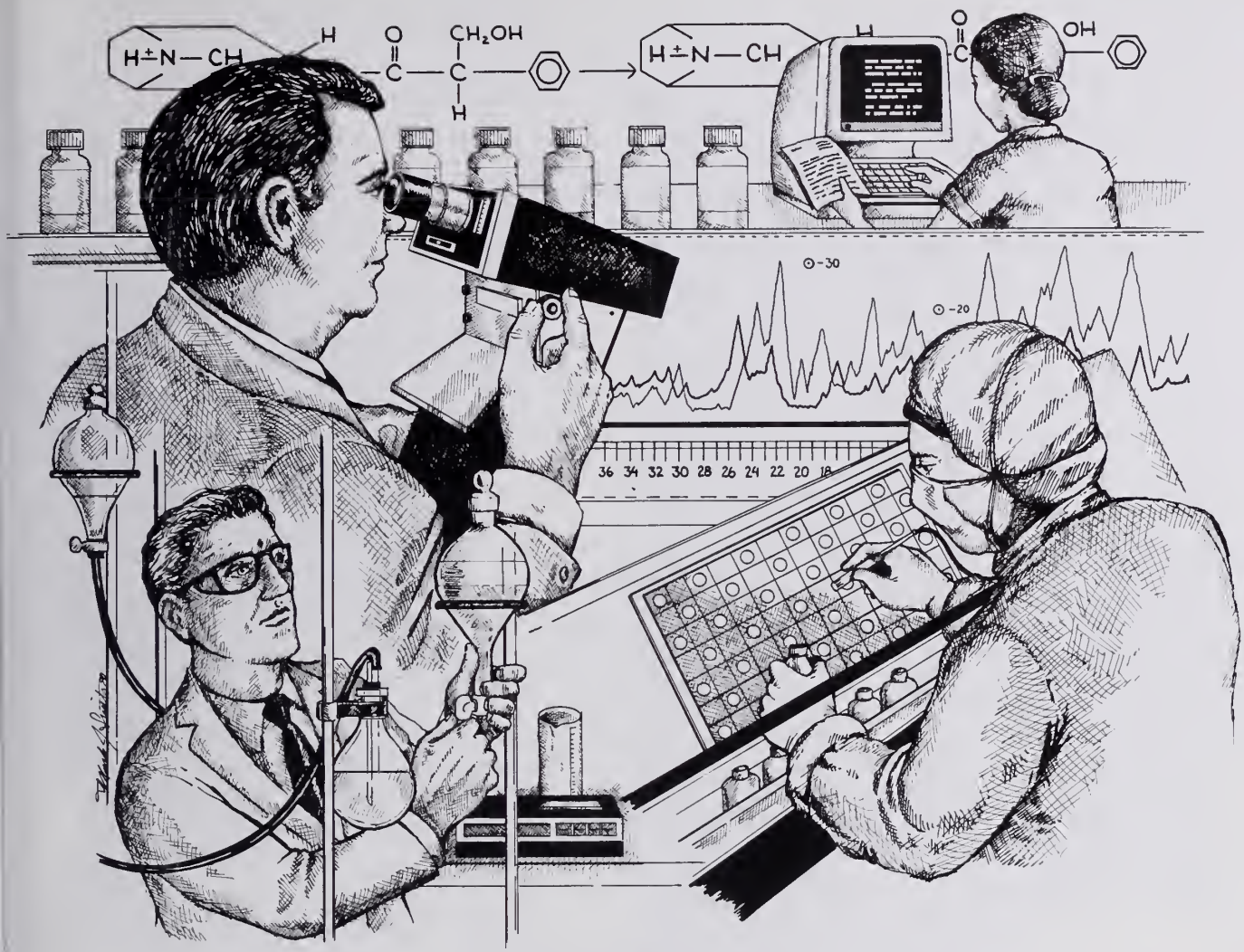
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Brief Summary

INDICATIONS: For the prevention and treatment of nocturnal recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis, and static foot deformities.

CONTRAINDICATIONS: Because of the quinine content, Quinamm is contraindicated in women of childbearing potential, in pregnancy, in patients with known quinine sensitivity, and in patients with glucose-6-phosphate dehydrogenase deficiency. Hemolysis (with the potential for hemolytic anemia) has been associated with a G-6-PD deficiency in patients taking quinine.

PRECAUTIONS: Thrombocytopenic purpura may follow the administration of quinine in highly sensitive patients. Recovery will follow withdrawal of the medication.
Cinchona alkaloids, including quinine, have the potential to depress the hepatic enzyme system that synthesizes the vitamin K-dependent factors. The resulting hypoprothrombinemic effect may enhance the action of warfarin and other oral anticoagulants.

ADVERSE REACTIONS: Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. If ringing in the ears, deafness, skin rash, or visual disturbances occur, the drug should be discontinued.

DOSAGE AND ADMINISTRATION:
1 tablet upon retiring. When necessary, 1 additional tablet may be taken following the evening meal.

Product Information as of September, 1977

U.S. Patent 2,985,558

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each tablet contains quinine sulfate 260 mg., aminophylline 195 mg.

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Nocturnal recumbency leg muscle cramping is frequently an unwelcome bedfellow for many patients—especially those with arthritis, diabetes or peripheral vascular disease... consider Quinamm... simple, convenient dosage—usually just one tablet at bedtime... can provide restful, welcome sleep without night leg cramps.

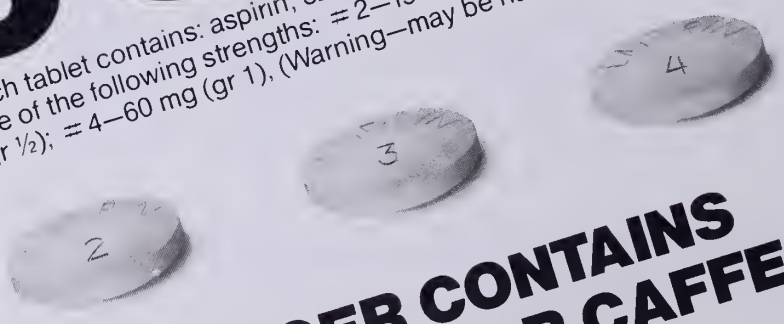
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Each tablet contains: aspirin, 325 mg; plus codeine phosphate in one of the following strengths: ≠2—15 mg (gr ¼); ≠3—30 mg (gr ½); ≠4—60 mg (gr 1), (Warning—may be habit-forming)



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The 4 in 1 Corticosteroid Cream

Anti-inflammatory, antifungal, antibacterial actions and, uniquely, a topical anesthetic for immediate relief of the itching or burning that frequently accompanies skin problems. One size (1/2 ounce), one strength for ease of prescription.

*This drug has been evaluated as possibly effective for these indications. See prescribing information on last page of this advertisement.

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The good tasting potassium supplement

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Note: In hypokalemic hypochloremic alkalosis, potassium chloride supplementation may be preferred.

1. Beeson-McDermott, Textbook of Medicine, 15th Ed. 1979, W.B. Saunders Co., Philadelphia, p. 1959

See prescribing information on last page of this advertisement.

or the Geriatric Patient

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acin	50 mg
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tamin B-2	5 mg
tamin B-6	1 mg
tamin B-12	3 mcg
oline	100 mg
ositol	50 mg
anganese (as Manganese Sulfate)	1 mg
agnesium (as Magnesium Sulfate)	2 mg
nc (as Zinc Sulfate)	1 mg
n (as Ferric Pyrophosphate, Soluble)	22 mg
cohol	18%

prescribing information on last page of this advertisement.



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Iodochlorhydroxyquin	3.0%
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INDICATIONS AND USAGE:

Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, FDA has classified the indications as follows, "Possibly effective": Contact or atopic dermatitis; impetiginized eczema; nummular eczema; infantile eczema; endogenous chronic infectious dermatitis; stasis dermatitis; pyoderma; nuchal eczema and chronic eczematoid otitis externa; acne urticata; localized or disseminated neurodermatitis; lichen simplex chronicus; anogenital pruritus (vulvae, scroti, ani), folliculitis; bacterial dermatoses; mycotic dermatoses such as tinea (capitis, cruris, corporis, pedis); moniliasis; intertrigo. Final classification on the less-than-effective indications requires further investigation.

Pramoxine Hydrochloride promptly relieves pain and itch. This compound may be used safely on the skin of those patients sensitive to the "caine" type local anesthetics.

CONTRAINDICATIONS: Hypersensitivity to F-E-P Creme, or any of its ingredients or related compounds; lesions of the eye; tuberculosis of the skin; most viral skin lesions (including herpes simplex, vaccinia and varicella).

WARNINGS: This product is not for ophthalmic use. In the presence of systemic infections, appropriate antibiotics should be used.

USE IN PREGNANCY: Topical steroids have not been reported to have an adverse effect on pregnancy. However, fetal abnormalities have been produced in pregnant laboatory animals that have been exposed to large doses of topical corticosteroids. Drugs of this class should not be used extensively during pregnancy.

PRECAUTIONS: F-E-P Creme may be irritating to the skin in some patients. If irritation occurs discontinue therapy. Staining of clothes or hair may also occur with use of this preparation. Although systemic toxicity has not been reported with this drug, adrenal pituitary suppression is possible, especially when the drug is used extensively or kept under an occlusive dressing for a prolonged period. Iodochlorhydroxyquin can be absorbed through the skin and interfere with thyroid function tests. Therapy with this preparation should stop at least a month before performance of these tests.

The ferric chloride test for phenylketonuria (PKU) can be positive if F-E-P Creme is on the diaper or in the urine. Prolonged use of this drug may result in an overgrowth of nonsusceptible organisms requiring appropriate therapy.

ADVERSE REACTIONS: Skin rash or hypersensitivity may occur following topical application. The following local adverse reactions have been reported with topical corticosteroids, especially under occlusive dressings: burning, itching, irritation, dryness, folliculitis, hypertrichosis, acneiform eruptions, hypopigmentation, perioral dermatitis, allergic contact dermatitis, maceration of the skin, secondary infection, skin atrophy, striae, miliara. Discontinue therapy if untoward reactions occur.

DOSAGE AND ADMINISTRATION: Apply a thin layer of the drug to affected parts 3-4 times daily.

Note:

1. **F-E-P Creme** is distributed with 3.0% iodochlorhydroxyquin for use when antibacterial/antifungal activity is desired.
2. **F-E-P Creme (Plain)** is the regular formulation, but without iodochlorhydroxyquin.

Both of these preparations contain pramoxine hydrochloride, which has topical anesthetic properties. Pramoxine is not chemically related to benzoic acid or amide type topical anesthetics. Patients can tolerate pramoxine although they may be sensitive to other "caine" type of topical or local anesthetics.

HOW SUPPLIED:

F-E-P Creme	F-E-P Creme Plain
½ ounce (15 gm) tubes	½ ounce (15 gm) tubes
NDC 0524-0026-51	NDC 0524-0025-51

CAUTION: Federal law prohibits dispensing without a prescription.

TWIN-K®

DESCRIPTION: Each 1S milliliter (tablespoonful) supplies 20 mEq of elemental potassium as a combination of potassium gluconate (15 mEq) and potassium citrate (5 mEq) in a sorbitol base with flavoring.

INDICATIONS AND USAGE: For use as oral potassium therapy in the prevention or treatment of hypokalemia which may occur secondary to diuretic or corticosteroid administration. It may be used in the treatment of cardiac arrhythmias due to digitalis intoxication.

CONTRAINDICATIONS: Severe renal impairment with oliguria or azotemia, untreated Addison's disease, adynamia episodica hereditaria, acute dehydration, heat cramps and hyperkalemia from any cause. This product should not be used in patients receiving aldosterone antagonists or triamterene.

WARNINGS: TWIN-K (potassium gluconate and potassium citrate) is a palatable form of oral potassium replacement. It appears that little if any potassium gluconate-citrate penetrates as far as the jejunum or ileum where enteric coated potassium chloride lesions have been noted. Excessive, undiluted doses of TWIN-K may cause a saline laxative effect.

To minimize gastrointestinal irritation it is recommended that TWIN-K be taken with meals or diluted with water or fruit juice. A tablespoonful (15 ml) in 8 ounces of water is approximately isotonic. More than a single tablespoonful should not be taken without prior dilution.

PRECAUTIONS: Potassium is a major intracellular cation which plays a significant role in body physiology. The serum level of potassium is normally 3.8—5.0 mEq/liter. While the serum or plasma level is a poor indicator of total body stores, a plasma or serum level below 3.5 mEq/liter is considered to be indicative of hypokalemia.

The most common cause of hypokalemia is excessive loss of potassium in the urine. However, hypokalemia can also occur with vomiting, gastric drainage and diarrhea.

Usually a potassium deficiency can be corrected by oral administration of potassium supplements. With normal kidney function it is difficult to produce potassium intoxication by oral administration. However, potassium supplements must be administered with caution since usually the exact amount of the deficiency is not accurately known. Checks on the patient's clinical status and periodic E.K.G. and/or serum potassium levels should be made. High serum potassium levels may cause death by cardiac depression, arrhythmias or arrest.

In patients with hypokalemia who also have alkalosis and a chloride deficiency (hypokalemic hypochloremic alkalosis), there will be a requirement for chloride ions. TWIN-K is not recommended for use in these patients.

ADVERSE REACTIONS: Symptoms of potassium intoxication include paresthesias of the extremities, flacid paralysis, listlessness, mental confusion, weakness and heaviness of the legs, fall in blood pressure, cardiac arrhythmias and heart block. Hyperkalemia may exhibit the following electrocardiographic abnormalities: disappearance of the P wave, widening and slurring of the QRS complex, changes of the ST segment and tall peaked T waves.

TWIN-K taken on an empty stomach in undiluted doses larger than 30 ml can produce gastric irritation with nausea, vomiting, diarrhea, and abdominal discomfort.

OVERDOSAGE: The administration of oral potassium supplements to persons with normal kidney function rarely causes serious hyperkalemia. However, if the renal excretory function is impaired potentially fatal hyperkalemia can result. It is important to note that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration with E.K.G. changes.

Treatment measures include:

1. Elimination of potassium containing drugs or foods.
2. Intravenous administration of 300 to 500 ml/hr of a 10% dextrose solution containing 10—20 units of crystalline insulin per 1000 milliliters.
3. Correction of acidosis.
4. Use of exchange resins or peritoneal dialysis.

In treating hyperkalemia it should be noted that patients stabilized on digitalis can develop digitalis toxicity when the serum potassium concentration is changed too rapidly.

DOSAGE AND ADMINISTRATION: The usual adult dosage is one tablespoonful (15 ml) in 6-8 fluid ounces of water or fruit juice, two to four times a day. This will supply 40 to 80 elemental potassium. The usual preventative dose of pota 20 mEq per day while therapeutic doses range from 30 100 mEq per day. Because of the potential for gastroin irritation, undiluted large single doses (30 ml or more) o are to be avoided.

Deviations from this schedule may be indicated, since no total daily dose can be defined, but must be governed b observation for clinical effects.

HOW SUPPLIED: Pint bottles. NDC 0524-0021-16

CAUTION: Federal law prohibits dispensing without a p tion.

SU-TON®

DESCRIPTION: Forty-five ml of SU-TON contains the fo ingredients:

Pentylenetetrazol	
Niacin	
Vitamin B-1	
Vitamin B-2	
Vitamin B-6	
Vitamin B-12	
Choline	
Inositol	
Manganese (as Manganese Sulfate)	
Magnesium (as Magnesium Sulfate)	
Zinc (as Zinc Sulfate)	
Iron (as Ferric Pyrophosphate, Soluble)	
Alcohol	

INDICATIONS AND USAGE: SU-TON contains pentylene which may be helpful in the older patient as an analept when mental confusion and memory defects are present. also contains vitamins, trace minerals, and iron, for those who may benefit by preventing the development of a de

CONTRAINDICATIONS: Epilepsy, convulsive disorders o history of sensitivity to any of the listed active ingredien

WARNINGS: The safety of this preparation during pregna lactation has not been established. Use of this drug requ the physician evaluate the potential benefits of the dru any possible hazard to the mother and child.

PRECAUTIONS: Although there are no absolute cont tions to pentylenetetrazol, it should be used with ca epileptic patients or those known to have a low co threshold or a focal brain lesion. Caution should be e when treating patients with high doses of SU-TON who h disease. While pentylenetetrazol does not act directl myocardium, the results from central vagal stimulatic cause bradycardia.

ADVERSE REACTIONS: Pentylenetetrazol in high do produce toxic symptoms typical of central nervou stimulants, which act on the higher motor centers and t cord. Convulsions resulting from this drug are spontan are not induced by external stimuli. They usually last fo minutes and are followed by profound depress respiratory paralysis. Death has been reported from the of 10 grams of pentylenetetrazol.

DRUG ABUSE: Drug dependence has not been repor SU-TON.

OVERDOSAGE: Signs and symptoms of acute overdos due principally from overstimulation of the central system and from excessive vasodilatation with i autonomic nervous system imbalance. The symptoms ma the following: vomiting, agitation, tremors, hyperreflex ing, confusion, hallucinations, headache, hypo tachycardia. Treatment consists of appropriate su measures. If signs and symptoms are not too severe patient is conscious, gastric evacuation may be accomp induction of emesis or gastric lavage.

Intensive care must be provided to maintain adequal tion and respiratory exchange.

DOSAGE AND ADMINISTRATION: One tablespoonful times a day 20-30 minutes before meals. This drug is not children under 12 years of age.

HOW SUPPLIED:

Bottles of 473 ml (16 fl oz) NDC 052

CAUTION: Federal law prohibits dispensing without a tion.

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Book Reviews

Book Review Editor — F. Norman Vickers, M.D.

Medicine and Literature, edited by Enid Rhodes Peschel. 204 pages. Price $15.00. Neale Watson Academic Publications, 156 Fifth Avenue, New York 10010.

Enid Rhodes Peschel, editor of *Medicine and Literature,* stated in her editor's note:

> Medicine and literature share profoundly, intimately an abiding concern for language and for those who wish to—who need to—communicate. The dialogue between medicine and literature is, essentially, a continuing interchange between the flesh and the word: between man's body and his spirit. Both medicine and literature probe, although from radially different perspectives, the same subject: the truths that are revealed—and concealed—in man.

This book which can be used as a text, reference or casual reading contains twenty-three chapters and is divided into three sections: (1) Doctor-writers, (2) Doctors portrayed in literature and, (3) Disease as an altered—or heightened—state of consciousness. As with most multiauthored books, some chapters vary in quality, or at least, in interest to this reviewer. Most of the authors are writers and teachers; three are physicians.

Dr. Edmund D. Pellegrino, now president of Catholic University of America, stated in his introduction:

> For the busy physician . . . literature has special virtures. It takes him from the grinding reality of the clinic into realms of imagination, lyricism and drama; it provides those moments of delectation without which the soul shrivels . . . Literature gives meaning to what the physican sees and it makes him see it feelingly. Whatever enriches the doctor's sensibilities must perforce make him a better physician.

This book, essentially a text, may stimulate some to read literature mentioned in its pages with better insight.

F.N.V.

Helping Hospital Trustees Understand Physicians by Richard E. Thompson, M.D. 82 pages. Paperback. Price $9.00. American Hospital Association, 840 North Lake Shore Drive, Chicago, Illinois 60611. 1979

Dr. Richard Thompson is a senior consultant, quality patient care at Illinois Hospital Research and Educational Foundation, an affiliate of the Illinois Hospital Association. Previously, he was on the staff of the Joint Commission on Accreditation of Hospitals (JCAH) and for five years prior, was chief of pediatrics at Medical Center Hospital, Columbus, Georgia. This book addresses ways of understanding physicians and obtaining cooperation among physicians, hospital administrators and hospital lay boards. Dr. Thompson has a unique perspective as clinician turned medical administrator.

It is implied that this book grew out of workshops in which the author participated emphasizing physician, hospital administration and lay board interaction and cooperation. The book, addressed to laymen, gives insights into the nature of medical practice and how it affects physicians' behavior; the nature of conflict and how to handle it constructively or ameliorate its effects. It describes case studies of cooperative approaches to problems such as hospital by-laws.

The book suggests trustee-administration-key physician retreats as one means of obtaining understanding and cooperation. The author, no doubt, knows how to survive in the real world. He suggests that hospital administrators not bulldoze physicians likely to be resistant to change, but rather to work with physicians likely to be flexible and receptive to ideas for improvement. Ask your friendly hospital administrator for a copy if you wish to know what your hospital trustees are reading.

F.N.V.

The Quotable Quotations Book, compiled by Alec Lewis. 333 pages. Price $12.95. Lippincott & Crowell, 521 Fifth Avenue, New York, New York 10017, 1980

"Unless one is a genius, it is best to aim at being intelligible."

—Anthony Hope Hawkins

"Let's hope the institution of marriage survives its detractors, for without it there would be no more adultery and without adultery, two-thirds of our novelists would stand in line for unemployment checks."

—Peter S. Prescott

"Doctors overawe us with their power over life and death and their unintelligible handwriting."

—David Hapgood, *New York Times*, 1-26-75

"If you have more surgeons, you'll get more surgery. If you have more internists, you'll get more lab tests."

—Dr. John Wennberg, quoted in *Newsweek*, 5-28-79

"Doctors are difficult people to live with because nobody ever says no to them."

—Divorced wife of physician, quoted in *New York Times*, 10-27-76

"When you're young you always assume sex was invented the day you hit puberty."

—Prof. John P. Roche, quoted in *Newsweek* 2-20-67

"If you don't know what it is, don't mess with it."

—Thomas E. "Fats" Waller, in answer to question on the nature of Jazz.

"We all go *do re mi*, but you got to find the other notes for yourself.

—Louis Armstrong, interview in *Reader's Digest*, December, 1971

"No woman can be too rich or too thin."

—Truman Capote on David Susskind Show, 1958

Seventeen years and 2,800 quotations later the compiler, Alec Lewis, has produced this book. Most quotes are contemporary. Famous people are quoted as well as cab drivers, laborers, children and other ordinary people. He chooses the one who says it best.

Use it for casual reading and reference. Give as a gift to student or friend. I liked it.

F.N.V.

Books Received

Receipt of the following books is acknowledged.

The Chemistry of Human Behavior by Herbert L. Meltzer, Ph.D. 261 Pages. Illustrated. Price $17.95 (cloth). Nelson-Hall Publishers, Chicago, 1979.

Annual Review of Neuroscience with 31 contributing authors. 555 Pages. Annual Reviews, Inc., Palo Alto, California, 1979.

Norethindrone, The First Three Decades edited by Mary Jean Pramik. 100 Pages. Syntex Laboratories, Palo Alto, California, 1978.

How To Improve Your Child's Behavior Through Diet by Laura J. Stevens and Rosemary B. Stoner. 346 Pages. Price $9.95. Doubleday & Company, Inc., New York, 1979.

Child Guidance by Samuel Kahn, M.D., Ph.D., F.R.S.H. 134 Pages. Price $10.00. Philosophical Library, Inc., New York, 1979.

The Vitamin Book by Rich Wentzler. 224 Pages. Price $4.95. Doubleday & Company, Inc., New York, 1979.

The Truth About Senility — And How To Avoid It by Lawrence Galton. 244 Pages. Price $9.95. Thomas Y. Crowell Company, New York, 1979.

Cooking Creatively for Your Diabetic Child by Caroline Hastings Babington. 224 Pages. Price $8.95. Doubleday & Company, Inc., New York, 1979.

Review of Physiological Chemistry by Harold A. Harper, Ph.D., Victor W. Rodwell, Ph.D., and Peter A. Mayes, Ph.D., D. Sc. 702 Pages. Price $14.50. Lange Medical Publications, Los Altos, California, 1977.

Clinical Anxiety/Tension in Primary Medicine: Proceedings of a Colloquium, Washington, D.C., Excerpta Medica, Lawrenceville, N.J.

Currents in Alcoholism, Vols. 3 and 4. Edited by Frank A. Seixas, M.D. 1099 Pages. Price $31.50 and $26.50. Grune & Stratton, Inc., New York, N.Y.

Handbook of Pediatrics by Henry K. Silver, M.D.; C. Henry Kempe, M.D. and Henry B. Bruyn, M.D. 730 Pages. Price $9.50. Lange Medical Publications, Los Altos, California, 1980.

Handbook of Poisoning, Tenth Edition, by Robert H. Dreisback, M.D. 578 Pages. Price $9.50. Lange Medical Publications, Los Altos, California, 1980.

General Ophthalmology, Ninth Edition, by Daniel Vaughan, M.D. and Taylor Asbury. 410 Pages. Price $15.00. Illustrated. Lange Medical Publications, Los Altos, California, 1980.

Controlling the Use of Therapeutic Drugs, An International Comparison, edited by William M. Wardell. 263 Pages. Price $4.75. Illustrated. American Enterprise Institute for Public Policy Research, Washington, D.C., 1978.

Annual Reviews Reprints: Immunology, 1977-1979, compiled by Irving Weissman. 466 pages. Illustrated. Annual Reviews, Palo Alto, California, 1980.

The Diabetic Gourmet, Revised Edition by Angela Bowen, M.D. 193 Pages. Price $10.95. Harper and Row, New York, 1980.

Current Pediatric Diagnosis and Treatment by C. Henry Kempe, M.D., Henry K. Silver, M.D., and Donough O'Brien, M.D. 1122 Pages. Illustrated. Price $20.00. Lange Medical Publications, Los Altos, California, 1980.

A Psychiatric Glossary, Fifth Edition. 142 Pages. Price $5.95. American Psychiatric Association, Washington, D.C., 1980.

Shocktrauma by Alan Doelp and John Franklin. 246 Pages. Price $9.95. St. Martin's Press, New York, 1980.

Review of Medical Microbiology, 14th Edition by Ernest Jawetz, Ph.D., M.D., Joseph L. Melnick, Ph.D. and Edward A. Adelberg, Ph.D. 593 Pages. Price $14.00. Illustrated. Lange Medical Publications, Los Altos, California, 1980.

Handbook of Obstetrics & Gynecology, Seventh Edition by Ralph C. Benson, M.D. 808 Pages. Price $10.00. Illustrated. Lange Medical Publications, Los Altos, California, 1980.

Breast Self-Examination by Albert R. Milan, M.D. 125 Pages. Paperback. Price $3.50. Workman Publishing Company, New York, 1980.

Handbook of Obstetrics and Gynecology by Ralph C. Benson, M.D. 808 Pages. Paperback. Price $10.00. Lange Medical Publications, Los Altos, California, 1980.

Ceasarian Childbirth, A Handbook for Parents by Christine Coleman Wilson and Wendy Roe Hovey. 297 Pages. Paperback. Price $6.95. Doubleday and Company, Inc., New York, 1980.

Directory of Pathology Training Programs, 1981-1982. 480 Pages. Paperback. Price $25.00. The Intersociety Committee on Pathology Information, Inc., Bethesda, Maryland, 1980.

Basic Histology by Luis C. Junqueira, M.D. and Jose Carneiro, M.D. 504 Pages. Paperback. Price $15.50. Lange Medical Publications, Los Altos, California, 1980.

Beyond Survival by the Work Group on Physician Well-Being, Resident Physicians Section, American Medical Association. 125 Pages. Paperback. Price $5.00. American Medical Association, Monroe, Wisconsin, 1980.

Emergency Handbook by Peter Arnold with Edward L. Pendayast Jr., M.D. 250 Pages. Price $11.95. Doubleday & Company, New York, 1980.

Whole Again by Lee Whipple. 232 Pages. Price $9.95. Caroline House Publishers, Inc., Ottawa, Illinois, 1980.

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SPECIAL ARTICLES

For What it Has Done for You

Editor's Note: *This article was condensed from "Medicine: It's a Beautiful Story," an address by Hoyt D. Gardner, M.D., of Louisville, Kentucky, President of the American Medical Association, presented before the West Virginia State Medical Association's 112th Annual Meeting, August 22, 1979.*

The American Medical Association is your association whether or not you are a member. It gives you professionalism, sets you apart, gives you credibility that allows you to be licensed and to maintain your practice. Because you are so certified, and always have been, you are the professional, you are the doctor, your credentials are in order.

This has come about because the AMA singly or jointly accredits all medical schools in the United States and Canada; the hospitals, ancillary and ambulatory health care facilities — voluntarily. No one mandates that this be done.

It is 139 years old with 215,000 dues-paying members. There have been 134 Presidents. Three states have provided eight Presidents each — Kentucky, Pennsylvania, and California.

The AMA is the largest publisher of scientific material in the world — 26 major publications, a weekly newspaper, a weekly journal with 38 billion copies distributed annually in this country, the Far East, South America, England, and China. One billion people benefit from this expertise and technology and through the World Medical Association an ongoing relationship is maintained with 141 countries.

There are 950 employees in Chicago and 30 in Washington and last year the budget amounted to $64 million. Of this total 85% was allocated to enhancement of the profession and betterment of the people's health. No other major organization in this country spends this proportion of its budget upon items outside its own structure.

Every licensed physician in the United States is known to AMA computers, the only organization that has this information. There are 407,000 physicians and 87,000 of these are colleagues from other countries.

This past year the House of Delegates had 274 members — a record number. From the House whose members are elected at state and county levels comes the only policy the Association has. It stands as a complete exemplification of grass roots support.

Three years ago we studied the sources of resolutions which became policy. Almost half of them originated with individual physicians in county medical societies who had ideas they thought were worthwhile. They submitted them to the judgment of colleagues at the county level who subsequently submitted a resolution to the state society, then to the AMA House of Delegates.

This is repetitive. It happens almost every time the House meets — almost one half the considerations come from physicians who have felt deeply and strongly that certain things should become policy. There is no better example of democracy in the world.

Between two sessions of the House each year custody is held by the Board of Trustees. Twelve of its members are elected by the Delegates, and the President, President-Elect and Immediate Past President complete the 15 members.

Medicine is the most regulated profession in the country and 80% is done by the physicians themselves. Tissue committees, peer review, and medical audits are being done voluntarily to insure quality of care.

Last year there were 19 million operations in hospitals and 34 million hospital admissions. Three million people visited physicians' office each day resulting in 9 million prescriptions. Medicine is represented by 51 specialties; 20 years ago there were 23.

There are 124 accredited medical schools in the United States and setting an all time record more than 16,000 students were graduated last year. For next year 64,000 students are enrolled, also a record in the history of medicine.

Forty-thousand physicians are involved in post-graduate medical education. There are 200,000 ongoing research projects and from research last year came 5,000 new descriptions of appliances, techniques, drugs and other procedures, and 1,000 newly described surgical procedures.

These are records being set in this country and all are the result of motivation to excel, to exceed, and to benefit.

No other country in the world has the quality of health care this nation enjoys; you only have to travel to find it out. But new challenges are ahead, approaching us rapidly, and we must be prepared to deal with them.

Since the beginning, medicine, law, religion and education, the four original learned professions, have been called upon for advice and consent, counseling, a sense of direction, as to what civilization should do when confronted with basic decisions. These professions have been the tutors when people must set priorities.

This is a rapidly shrinking world. There is no abundance of resources any more and those we have are rapidly being utilized. As a consequence, civilization is turning to the learned professions for direction. In this country no organization can speak for medicine except the American Medical Association.

If there is a challenge that rests upon your shoulders it is at least this much. You must give the organization the strength to continue to speak and to provide a sense of direction. If you feel any sense of responsibility whatsoever not only for your profession but for civilization itself, you owe the AMA at least your membership. For all it has done for you, and most of all for what it has done and will continue to do for so many in the years to come, you need to show appreciation and recognition.

Everybody Needs Friends

Last Christmas my college senior came home mumbling he'd learned the most important lesson of his life: "Always State the Obvious." At the time I assessed this Magnificat at about $3,500 a syllable and forgot it. Now, however, I think the boy was absolutely correct for nearly every day one can see failures and breakdowns due to the simplest, most basic factors being ignored or overlooked. Probably this happens because people just take the obvious for granted, which can be a big mistake.

In the field of medicine, for instance I think rapport is too often taken for granted. Everybody would agree that one of the most basic and obvious tools is a good rapport between patient and physician. Rapport is defined as "a sympathetic harmonious relationship between people," which also happens to be a good definition for friendship. Unfortunately, however, doctors tend to take rapport so much for granted they think it just automatically exists when they see a patient, and they couldn't be more wrong.

One reason rapport may be so often lacking is that physicians aren't really specifically trained for it. To be a school teacher, for example, one takes a number of psychology courses, the study of normal behavior, as it's considered important for a teacher to know how people think, learn and react. Physicians, on the other hand, are often not required to take a single hour of psychology, only psychiatry. Apparently it's not considered valuable for a physician to know much about how normal people think and behave. Yet, everyday, physicians deal with people on matters far more important than do school teachers.

Also, it seems that medical schools often get so caught-up in the teaching of science and pathology that sometimes everybody forgets they are dealing with people as well as with protoplasm. What then happens is that physicians, trained-up on spotting pathology, go right into practice still viewing pathology instead of seeing normal people who just happen to have a medical problem. Priorities get reversed. Quite often patients need applied psychology as much as they need medical treatment; which is to say patients need sympathetic communication with a friend who cares about them, as much as any medicine. Too often, however, what patients find is a pathology-seeker instead of a friend.

Too, in our particular area, the constant migration of our population may contribute to the problem as much as anything. Frequently even neighbors don't have time to become friends.

Whatever the cause, however, there is a serious and pervasive breakdown of communication between people which should be of great concern to the medical community. This breakdown occurs between patient

and physician, among physicians themselves and extends to hospitals, as well. Here we are in an age of instant communication around the world and yet people in the same community, even in the same office are unable to talk to one another. The word "talk" is probably the wrong one to use as there is much of that going on, just little communication.

It's quite common to hear doctors refer to "the gal with the ulcer" or even "that kidney," but it may come as a shock to physicians to realize it's a two-way street. Last week my husband did an insurance physical for a woman with three surgeries in her history: gallbladder, hysterectomy and breast biopsy. Each was done by a different physician but she could recall the name of only one doctor. And my husband says this happens with about half his people. They simply don't remember who treated them, often for significant problems. So while doctors are busily seeing patients as pieces of pathology, it's equally true that patients are busily seeing physicians as nameless strangers. All this may be poetic justice, but it's just not right. Everybody deserves to be treated as a person whichever side of the street he treads.

This blatant unconcern for personal relationships is not only wrong, it is extremely costly. A simple lack of rapport between patient and physician is undoubtedly the single, most overwhelming cause of malpractice suits. Certainly some people will always just be looking for easy money, just as some physicians really deserve to be sued, but by and large people strike-out against a stranger. Nobody wants to set out to hurt a friend. Undoubtedly, physicians were so seldom sued in the past largely because they and their patients were real friends in addition to being patient and physician.

If physicians today would just make more of an effort to see their patients as people first, and frightened, worried people at that, rapport would come very easily and they and their patients would often come to be real friends. That's important because a good friend might easily prove worth a million dollars one day. It's also the way people are supposed to live. Perhaps you will agree that to state the obvious does have merit, and further, it's worth some effort to give the obvious a try.

Elizabeth Carpenter (Mrs. N. H.)
Fort Lauderdale

Guest Editorial reprinted from The Record, Official Bulletin, Broward County Medical Association, January 1980.

The Profession and Ethics

Amos Prevatt, M.D.

In recent years the learned professions have been under seige and are not admired and respected as before. The scientists are blamed for nuclear fallout from bombs and for malfunctions such as occurred at Three Mile Island. Academicians are held accountable for student unrest in the 1960's and for Johnny's not being able to read. The clergy are looked upon as possessing more human failings than before. Lawyers are seen as more deceitful. Watergate has lowered the respect for politicians. The public revelations of Wayne Hayes' friend, Ms. Ray, have impaired the reputation of even the oldest profession.

All of us in medicine are shamed by disclosures of malpractice. Medicaid and other fraud by physicians have been presented on prime time television. Medicine has been under especially hard fire due to its previous pre-eminence as a profession.

The status of a profession goes up and down like the stock market responding to public popularity. Over a century ago Oliver Wendell Holmes wrote convincingly of how sensitive medicine is to outside influences. The effects of culture on medicine are very evident today.

The Federal Trade Commission in 1975 accused the American Medical Association of stifling competition through its Principles of Medical Ethics and particularly through its statement that physicians should not solicit patients. The chairman of the FTC is concerned with rising medical costs; he regards medicine as a business and trade. He attacks both the profession of medicine and the ethics of medicine.

Abraham Flexner defined a profession as possessing certain portions of many sciences arranged and organized with a distinct practical purpose in view. Thus, medicine is a profession and can not be treated as a

business. The chairman of the FTC is wrong.

Ethical principles are guides to correct conduct derived from moral precepts but generally more restrictive. They are applied to a group whose obligations to society are different from those of the community as a whole.

In 1520 the Royal College of Physicians of London drew up a constitution and organizational statutes setting out the duties of members and prescribing penalties for violations. These statutes were originally called "penal". Probably at the suggestion of a public relations consultant, the adjective was later changed to "ethical".

These ethical statutes were the basis on which the AMA formulated its code of ethics in 1847. The code was centered on the organization and contributed to the rise of medicine to preeminence in health matters. The code and the subsequent Principles of Medical Ethics have been revised several times but they are still centered on the organization rather than on the patient.

In 1978 the House of Delegates of the AMA considered a proposed revision to the Principles of Medical Ethics. It was pointed out that legal codes and mores change. Society's present attitude toward abortion is an example. Medicine does and must respond to societal changes and our code should be revised to account for these. An Ad Hoc Committee of the AMA is currently considering changes in our Principles of Medical Ethics.

A theory of professionalism has arisen through the years which accords a profession special status. In recognition of this the profession embraces an ethic of service in which dedication to a patient's interest takes preference over personal profit. There is an obligation to reach for excellence in securing the needs of the patient.

The Ad Hoc Committee of the AMA is to recommend that our new ethics do believe in this theory of professionalism. This patient-centered ethic should have solid committment by our profession. The profession has the will to police itself with no thought of public relations, to hold that ethical behavior is desirable, widely practiced, approved and advised.

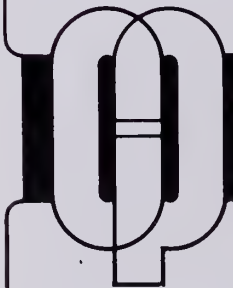
The truly exalted status that medicine has achieved in our own community is due to the ethical behavior of physicians who have practiced before us. We who now begin practice are automatically awarded this status which was earned by our predecessors. Older patients frequently recite to me examples of the ethical behavior of Pensacola physicians who have since passed. Drs. Ames, Payne, Morse, White, Lischkoff and many others are still mentioned as "good doctors". This, then, is the highest compliment a physician can receive — to be a "good doctor". To accept the obligations that our privileges impose upon us as a professional: to promote the welfare of our patients and the community.

How should the chairman of the FTC be answered when he charges that professionals are business cartels bent on gouging the public? How should we respond to bureaucratic health regulators and planners? We should answer that we are a profession; that our paramont interest is in the welfare of our patients; that we support proposals that benefit our patients.

Reprinted from the Escambia County Medical Society Bulletin, February 1980.

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Brief Summary of Prescribing Information

Indications and Usage: Symptomatic relief of anxiety, tension, agitation, irritability an insomnia associated with anxiety neuroses and transient situational disturbances, anxiet associated with depressive symptoms and as a treatment of symptoms of anxiety if such symp toms are a significant feature of functional or organic disorders, particularly gastrointestinal c cardiovascular

Effectiveness in long-term use, i e , more than 4 months, has not been assessed by system atic clinical studies Reassess periodically usefulness of the drug for the individual patient.

Contraindications: Known sensitivity to benzodiazepines or acute narrow-angle glaucoma

Warnings: Not recommended in primary depressive disorders or psychoses. As with all CNS acting drugs, warn patients on lorazepam not to operate machinery or motor vehicles, and c diminished tolerance for alcohol and other CNS depressants.

Physical and Psychological Dependence Withdrawal symptoms like those noted with barb turates and alcohol have occurred following abrupt discontinuance of benzodiazepine (including convulsions, tremor, abdominal and muscle cramps, vomiting and sweating) Addic tion-prone individuals, e g drug addicts and alcoholics, should be under caretul surveillanc when on benzodiazepines because of their predisposition to habituation and dependence Withdrawal symptoms have also been reported following abrupt discontinuance of benzod azepines taken continuously at therapeutic levels for several months

Precautions: In depression accompanying anxiety, consider possibility for suicide.

For elderly or debilitated patients, initial daily dosage should not exceed 2mg to avoid ove sedation

Terminate dosage gradually since abrupt withdrawal of any antianxiety agent may result symptoms like those being treated. anxiety, agitation, irritability, tension, insomnia and occ sional convulsions

Observe usual precautions with impaired renal or hepatic function

Where gastrointestinal or cardiovascular disorders coexist with anxiety, note that lorazepa has not been shown of significant benefit in treating gastrointestinal or cardiovascular comp nent

Esophageal dilation occurred in rats treated with lorazepam for more than 1 year 6mg kg day No effect dose was 1 25mg kg day (approximately 6 times the maximum huma therapeutic dose of 10mg day) Effect was reversible only when treatment was withdrawn with 2 months of first observation. Clinical significance is unknown; but use of lorazepam for pr longed periods and in geriatric patients requires caution and frequent monitoring for sympton of upper G I disease

Safety and effectiveness in children under 12 years have not been established

ESSENTIAL LABORATORY TESTS Some patients have developed leukopenia, some have h elevations of LDH As with other benzodiazepines, periodic blood counts and liver function tes are recommended during long-term therapy

CLINICALLY SIGNIFICANT DRUG INTERACTIONS. Benzodiazepines produce CNS depressa effects when administered with such medications as barbiturates or alcohol.

CARCINOGENESIS AND MUTAGENESIS. No evidence of carcinogenic potential emerged rats during an 18-month study No studies regarding mutagenesis have been performed.

PREGNANCY Reproductive studies were performed in mice, rats, and 2 strains of rabbi Occasional anomalies (reduction of tarsals, tibia, metatarsals, malrotated limbs, gastroschis malformed skull and microphthalmia) were seen in drug-treated rabbits without relationship dosage Although all these anomalies were not present in the concurrent control group, th have been reported to occur randomly in historical controls At 40mg/kg and higher, there w evidence of fetal resorption and increased fetal loss in rabbits which was not seen at low doses Clinical significance of these findings is not known. However, increased risk of conge tal malformations associated with use of minor tranquilizers (chlordiazepoxide, diazepam a meprobamate) during first trimester of pregnancy has been suggested in several studie Because use of these drugs is rarely a matter of urgency, use of lorazepam during this per should almost always be avoided Possibility that a woman of child-bearing potential may pregnant at institution of therapy should be considered Advise patients if they become pre nant to communicate with their physician about desirability of discontinuing the drug

In humans, blood levels from umbilical cord blood indicate placental transfer of lorazepa and its glucuronide

NURSING MOTHERS It is not known if oral lorazepam is excreted in human milk like oth benzodiazepines As a general rule, nursing should not be undertaken while on a drug sin many drugs are excreted in milk

Adverse Reactions, if they occur, are usually observed at beginning of therapy and genera disappear on continued medication or on decreasing dose. In a sample of about 3,500 anxio patients, most frequent adverse reaction is sedation (15 9%), followed by dizziness (6 9% weakness (4 2%) and unsteadiness (3 4%) Less frequent are disorientation, depression, na sea change in appetite, headache, sleep disturbance, agitation, dermatological symptoms, e function disturbance, various gastrointestinal symptoms and autonomic manifestations. In dence of sedation and unsteadiness increased with age Small decreases in blood pressu have been noted but are not clinically significant, probably being related to relief of anxiety.

Overdosage: In management of overdosage with any drug, bear in mind that multiple ager may have been taken Manifestations of overdosage include somnolence, confusion and com Induce vomiting and/or undertake gastric lavage followed by general supportive care, monit ing of vital signs and close observation Hypotension, though unlikely, usually may be controll with Levarterenol Bitartrate Injection U S P Usefulness of dialysis has not been determined

Ativan®(IV) for (lorazepam) Anxiety

Dosage: **Individualize for maximum beneficial effects. Increase do gradually when needed, giving higher evening dose before increasi daytime doses. Anxiety, usually 2-3mg/day given b.i.d. or t.i.d.; dosag may vary from 1 to 10mg/day in divided doses. For elderly or debi tated, initially 1-2mg/day; insomnia due to anxiety or transient situ tional stress, 2-4mg h.s.**

How Supplied: **0.5, 1.0 and 2.0mg tablets.**

Wyeth Laboratories
Philadelphia, PA 19101

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Why one benzodiazepine and not another?

Are you concerned about long-acting metabolites? Many clinicians, as well as pharmacologists, are beginning to draw attention to this problem (see New England Journal of Medicine, April 5, 1979).

In contrast to some older benzodiazepines, Ativan (lorazepam) does not give rise to long-lasting active metabolites. As with all benzodiazepines, you should follow the usual precautions concerning co-administration with other CNS depressants and warn your patients against operating dangerous machinery and motor vehicles.

However, it is noteworthy that Ativan showed no clinical evidence of accumulation even when given in high doses over periods up to 6 months. The half-life of free lorazepam is about 12 hours; steady-state serum levels are attained in 2-3 days. Comparable data for diazepam: 20-50 hours and at least 7-10 days. (The pharmacokinetic profile of a drug can define such characteristics as absorption, distribution, metabolism and elimination but cannot, at present, be directly related to its therapeutic effectiveness.)

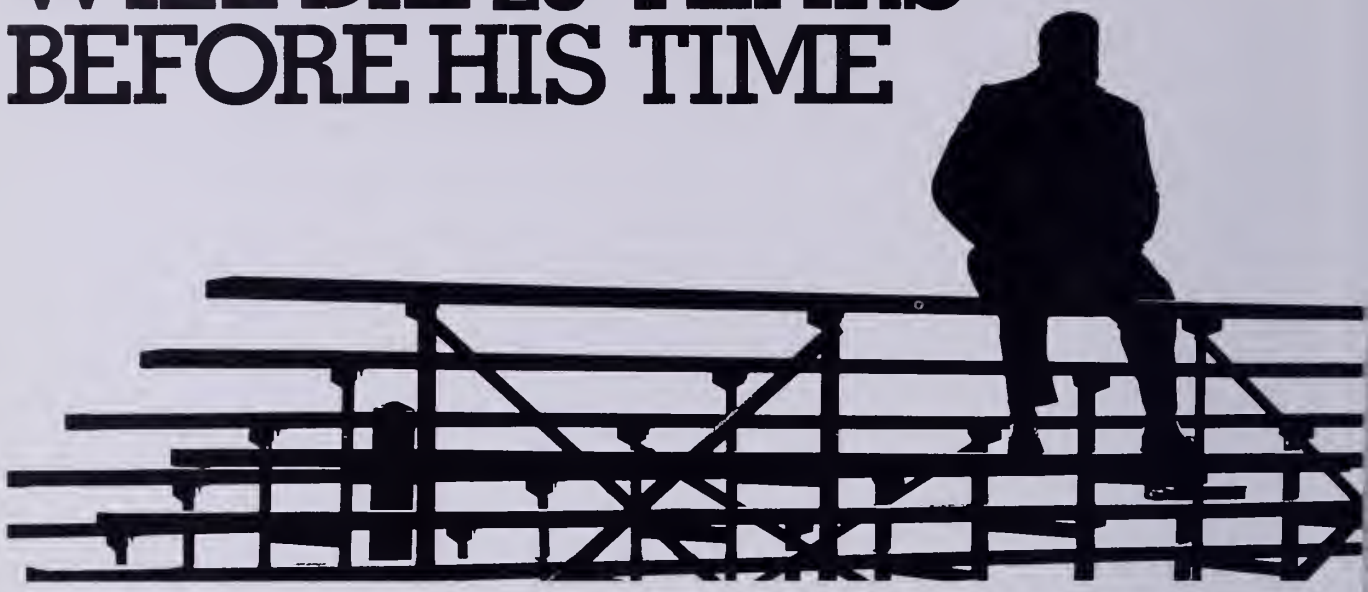
Ativan has a convenient b.i.d. or t.i.d. dosage schedule; it is compatible with a long list of other medications and, of course, it is a highly effective anxiolytic agent, as established in numerous nationwide, double-blind, controlled evaluations in thousands of patients.



See important information on preceding page.

Ativan® (lorazepam) **for Anxiety**

THIS FORMER ALL-STATE HALFBACK WILL DIE 20 YEARS BEFORE HIS TIME



Back in college he was always in great shape. But, like too many other Americans, the end of his college career signaled the end of his regular physical activity.

Years of business pressure, poor diet and a sedentary lifestyle have conspired to steal away his good health and cut years from his life expectancy. Now he's a prime candidate for heart disease—the number one cause of death and disability in the U.S.

Don't let the same thing happen to you. If you left your active lifestyle back in school, get moving again. Start a moderate program of regular lifetime sports like golf, tennis, biking, jogging, bowling or swimming. Start your new program with a check-up by your physician. It can help you feel better, look better and live better.

Just a little activity and recreation can make a big difference in your whole outlook on life. And the sooner you get moving, the longer you'll be able to move.

KEEP MOVING, AMERICA!

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Health and Safety Tip

From the American Medical Association

535 North Dearborn Street/Chicago, Illinois 60610

Air Travelers Face Jet Lag Fatigue

Jet Lag Is Hazard

The most obvious contributor to stress in the modern world travel style is "jet lag fatigue."

An air traveler who departs from New York for Italy at 5:30 p.m. crosses seven time zones during a seven-hour flight, and arrives in Rome at 7:30 a.m. Rome time. But it is 12:30 a.m. in New York, the middle of the night for the traveler.

There is great variability in the effects of time zone changes and in one's speed of adjustment, the American Medical Association points out. The young adjust easily; older individuals more slowly.

Tourists planning months in advance for an overseas vacation should take conditioning exercises; a two to three-week program of walking up to three miles a day. Avoid the Bon Voyage party, unless it is given two or three days prior to departure.

In flight, remember that two drinks at cruising altitude are the equivalent of three or four on the ground. Eat moderately and drink sparingly. Get up and walk about the plane frequently.



The single most important requirement on arrival at the overseas destination is sleep and rest. A flight to Europe should be followed by a good night's sleep before sightseeing or business.

A simple formula often is used by tour groups. It calls for rest stops of a day after crossing four to six time zones, and two days after seven to ten zones. As crossings approach a complete reversal of the day-night cycle, three days of rest are welcomed by any traveler, particularly if in late middle age or afflicted with insomnia.

North-south flights cross no time zones, or only one, and should result in only normal fatigue.

A pretravel health review with your physician may help forestall health emergencies while on tour. There are some individuals who should not board long jet flights. These include women beyond the eighth month of pregnancy, infants less than two weeks old, individuals with contagious disease, those with large unsupported hernias, psychotics, acute respiratory infection patients (severe colds or flu), those with certain heart problems (ask your doctor), and poorly stabilized convalescent postoperative or handicapped people.

Jet lag fatigue may be held to a minimum by proper planning and proper rest on arrival.

August, 1980
Frank Chappell
Science News Editor
AMA


getting back
to business

with symptomatic relief of moderate anxiety with depression

Rapid relief of anxiety

The tranquilizer component alleviates symptoms of anxiety within a few days without apparent dulling of mental acuity. Hypnotic effects appear to be minimal, particularly in patients permitted to remain active. However, TRIAVIL may impair mental and/or physical abilities required for the performance of hazardous tasks.

Dependable antidepressant action

The antidepressant component relieves symptoms of depression such as poor concentration and feelings of hopelessness as well as early morning awakening; adequate relief of symptoms may take a few weeks or even longer.

for moderate anxiety with depression

dual-action **Triavil**®

containing perphenazine and amitriptyline HCl

Treatment with TRIAVIL— a balanced view

TRIAVIL is contraindicated in CNS depression from drugs, in the presence of evidence of bone marrow depression, and in patients hypersensitive to phenothiazines or amitriptyline. It should not be used during the acute recovery phase following myocardial infarction or in patients who have received an MAOI within two weeks. Patients with cardiovascular disorders should be watched closely. Not recommended in children or during pregnancy. TRIAVIL may enhance the response to alcohol. Antiemetic effects may obscure toxicity due to overdosage of other drugs or mask other disorders. The possibility of suicide in depressed patients remains until significant remission occurs. Such patients should not have access to large quantities of the drug. Hospitalize as soon as possible any patient suspected of having taken an overdose.

MSD
MERCK SHARP & DOHME

Please see the following page for a brief summary of prescribing information.

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by providing symptomatic relief of moderate anxiety with depression

dual-action TRIAVIL®

containing perphenazine and amitriptyline HCl

helps patients get back to business

Available:
TRIAVIL® 2-25: Each tablet contains
2 mg perphenazine and 25 mg amitriptyline HCl.
TRIAVIL® 2-10: Each tablet contains
2 mg perphenazine and 10 mg amitriptyline HCl.
TRIAVIL® 4-50: Each tablet contains
4 mg perphenazine and 50 mg amitriptyline HCl.
TRIAVIL® 4-25: Each tablet contains
4 mg perphenazine and 25 mg amitriptyline HCl.
TRIAVIL® 4-10: Each tablet contains
4 mg perphenazine and 10 mg amitriptyline HCl.

CONTRAINDICATIONS: Central nervous system depression from drugs (barbiturates, alcohol, narcotics, analgesics, antihistamines); evidence of bone marrow depression; known hypersensitivity to phenothiazines or amitriptyline. Should not be given concomitantly with a monoamine oxidase inhibitor since hyperpyretic crises, severe convulsions, and deaths have occurred from such combinations. When used to replace a monoamine oxidase inhibitor, allow a minimum of 14 days to elapse before initiating therapy with TRIAVIL. Therapy should then be initiated cautiously with gradual increase in dosage until optimum response is achieved. Not recommended for use during acute recovery phase following myocardial infarction.

WARNINGS: TRIAVIL should not be given concomitantly with guanethidine or similarly acting compounds since TRIAVIL may block the antihypertensive action of such compounds. Use cautiously in patients with history of urinary retention, angle-closure glaucoma, increased intraocular pressure, or convulsive disorders. Dosage of anticonvulsive agents may have to be increased. In patients with angle-closure glaucoma, even average doses may precipitate an attack. Patients with cardiovascular disorders should be watched closely. Tricyclic antidepressants, including amitriptyline HCl, have been reported to produce arrhythmias, sinus tachycardia, and prolongation of conduction time, particularly in high doses. Myocardial infarction and stroke have been reported with tricyclic antidepressant drugs. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. May impair mental and/or physical abilities required for performance of hazardous tasks, such as operating machinery or driving a motor vehicle. In patients who use alcohol excessively, potentiation may increase the danger inherent in any suicide attempt or overdosage. Not recommended in children or during pregnancy.

PRECAUTIONS: Suicide is a possibility in depressed patients and may remain until significant remission occurs. Such patients should not have access to large quantities of this drug.

Perphenazine: Should not be used indiscriminately. Use with caution in patients who have previously exhibited severe adverse reactions to other phenothiazines. Likelihood of some untoward actions is greater with high doses. Closely supervise with any dosage. The antiemetic effect of perphenazine may obscure signs of toxicity due to overdosage of other drugs or make more difficult the diagnosis of disorders such as brain tumor or intestinal obstruction. A significant, not otherwise explained, rise in body temperature may suggest individual intolerance to perphenazine, in which case discontinue.

If hypotension develops, epinephrine should not be employed, as its action is blocked and partially reversed by perphenazine. Phenothiazines may potentiate the action of central nervous system depressants (opiates, analgesics, antihistamines, barbiturates, alcohol) and atropine. In concurrent therapy with any of these, TRIAVIL should be given in reduced dosage. May also potentiate the action of heat and phosphorous insecticides. There is sufficient experimental evidence to conclude that chronic administration of antipsychotic drugs which increase prolactin secretion has the potential to induce mammary neoplasms in rodents under the appropriate conditions. There are recognized differences in the physiological role of prolactin between rodents and humans. Since there are, at present, no adequate epidemiological studies, the relevance to human mammary cancer risk from prolonged exposure to perphenazine and other antipsychotic drugs is not known.

Amitriptyline: In manic-depressive psychosis, depressed patients may experience a shift toward the manic phase if they are treated with an antidepressant. Patients with paranoid symptomatology may have an exaggeration of such symptoms. The tranquilizing effect of TRIAVIL seems to reduce the likelihood of this effect. When amitriptyline HCl is given with anticholinergic agents or sympathomimetic drugs, including epinephrine combined with local anesthetics, close supervision and careful adjustment of dosages are required. Paralytic ileus may occur in patients taking tricyclic antidepressants in combination with anticholinergic-type drugs.

Caution is advised if patients receive large doses of ethchlorvynol concurrently. Transient delirium has been reported in patients who were treated with 1 g o ethchlorvynol and 75-150 mg of amitriptyline HCl.

Amitriptyline HCl may enhance the response to alcohol and the effects o barbiturates and other CNS depressants.

Concurrent administration of amitriptyline HCl and electroshock therapy ma increase the hazards associated with such therapy. Such treatment should be limited to patients for whom it is essential. Discontinue several days before elective surgery if possible. Elevation and lowering of blood sugar levels have both been reported. Use with caution in patients with impaired liver function.

ADVERSE REACTIONS: Similar to those reported with either constituent alone

Perphenazine: Extrapyramidal symptoms (opisthotonus, oculogyric crisis hyperreflexia, dystonia, akathisia, acute dyskinesia, ataxia, parkinsonism) hav been reported and can usually be controlled by the concomitant use of effectiv antiparkinsonian drugs and/or by reduction in dosage, but sometimes persist afte discontinuation of the phenothiazine.

Tardive dyskinesia may appear in some patients on long-term therapy or ma occur after drug therapy with phenothiazines and related agents has bee discontinued. The risk appears to be greater in elderly patients on high-dos therapy, especially females. Symptoms are persistent and in some patients appea to be irreversible. The syndrome is characterized by rhythmical involuntar movements of the tongue, face, mouth, or jaw. Involuntary movements of th extremities sometimes occur. There is no known treatment for tardive dyskinesi antiparkinsonism agents usually do not alleviate the symptoms. It is advised that a antipsychotic agents be discontinued if the above symptoms appear. If treatment reinstituted, or dosage of the particular drug increased, or another drug subst tuted, the syndrome may be masked. Fine vermicular movements of the tongu may be an early sign of the syndrome. The full-blown syndrome may not develo if medication is stopped when lingual vermiculation appears.

Other side effects are skin disorders (photosensitivity, itching, erythem urticaria, eczema, up to exfoliative dermatitis); other allergic reactions (asthm laryngeal edema, angioneurotic edema, anaphylactoid reactions); peripher edema; reversed epinephrine effect, hyperglycemia; endocrine disturbance (lactation, galactorrhea, gynecomastia, disturbances of menstrual cycle); altere cerebrospinal fluid proteins; paradoxical excitement, hypertension, hypotensio tachycardia, and ECG abnormalities (quinidine-like effect); reactivation of ps chotic processes; catatonic-like states; autonomic reactions, such as dry mou or salivation, headache, anorexia, nausea, vomiting, constipation, obstipatio urinary frequency or incontinence, blurred vision, nasal congestion, and a chang in pulse rate; other adverse reactions reported with various phenothiazir compounds, but not with perphenazine, include grand mal convulsions, cerebr edema, polyphagia, pigmentary retinopathy, photophobia, skin pigmentation, ar failure of ejaculation.

The phenothiazine compounds have produced blood dyscrasias (pancyt penia, thrombocytopenic purpura, leukopenia, agranulocytosis, eosinophilia and liver damage (jaundice, biliary stasis).

Pigmentation of the cornea and lens has been reported to occur after long-ter administration of some phenothiazines. Although it has not been reported patients receiving TRIAVIL, the possibility that it might occur should be considere

Hypnotic effects, lassitude, muscle weakness, and mild insomnia have al been reported.

Amitriptyline: Note: Listing includes a few reactions not reported for this drug, b which have occurred with other pharmacologically similar tricyclic antidepressa drugs and must be considered when amitriptyline is administered. *Cardiovasc lar:* Hypotension; hypertension; tachycardia; palpitation; myocardial infarctic arrhythmias; heart block; stroke. *CNS and Neuromuscular:* Confusional state disturbed concentration; disorientation; delusions; hallucinations; exciteme anxiety; restlessness; insomnia; nightmares; numbness, tingling, and paresthesi of the extremities; peripheral neuropathy; incoordination; ataxia; tremors; s zures; alteration in EEG patterns; extrapyramidal symptoms; tinnitus; syndrome inappropriate ADH (antidiuretic hormone) secretion. *Anticholinergic:* Dry mou blurred vision; disturbance of accommodation; increased intraocular pressu constipation; paralytic ileus; urinary retention; dilatation of urinary tract. *Allerg* Skin rash; urticaria; photosensitization; edema of face and tongue. *Hematolog* Bone marrow depression including agranulocytosis; leukopenia; eosinophil purpura; thrombocytopenia. *Gastrointestinal:* Nausea; epigastric distress; vom ing; anorexia; stomatitis; peculiar taste; diarrhea, parotid swelling; black tongu Rarely hepatitis (including altered liver function and jaundice). *Endocrine:* Test ular swelling and gynecomastia in the male; breast enlargement and galactorrh in the female; increased or decreased libido; elevated or lowered blood sug levels. *Other:* Dizziness, weakness; fatigue; headache; weight gain or lo increased perspiration; urinary frequency; mydriasis; drowsiness; alopecia. *Wi drawal Symptoms:* Abrupt cessation after prolonged administration may produ nausea, headache, and malaise. These are not indicative of addiction.

OVERDOSAGE: All patients suspected of having taken an overdosage should admitted to a hospital as soon as possible. Treatment is symptomatic a supportive. However, the intravenous administration of 1–3 mg of physostigm salicylate is reported to reverse the symptoms of tricyclic antidepressant poiso ing. Because physostigmine is rapidly metabolized, the dosage of physostigm should be repeated as required particularly if life-threatening signs such arrhythmias, convulsions, and deep coma recur or persist after the initial dosage physostigmine. On this basis, in severe overdosage with perphenazine-amitr tyline combinations, symptomatic treatment of central anticholinergic effects w physostigmine salicylate should be considered.

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For more detailed information, consult your MSD Representative or see full Prescribing Information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486.

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AMA Auxiliary Convention

The Annual Convention of the American Medical Association Auxiliary was held July 19-23 at the Drake Hotel, Chicago. There was a burst of orange as the Florida delegation, 17 members strong, stood to answer the official roll call. In brilliant orange hats and jackets, the Sunshine State auxilians were a colorful picture of unity and enthusiasm. Delegates were Mrs. B. David Epstein, Mrs. Fred P. Swing, Mrs. Jack Carver, Mrs. N.H. Carpenter, Mrs. Frank Coleman, Mrs. James Corwin, Mrs. Arthur Eberly, Mrs. Irving Fixel, Mrs. Walter Jarrell, Mrs. V.A. Marks, Mrs. R.B. Moore, Mrs. Daniel B. Nunn, Mrs. Rex Orr, Mrs. Theodore Sarafoglu, Mrs. Thomas B. Thames, Mrs. Milton Tignor Jr., and Mrs. Pennington Wimbush.

Mrs. Epstein was elected to the 1980-81 National Nominating Committee, and in her honor the Florida delegation hosted a Sunshine Punch Party for some 300 delegates and National Board members. They distributed fliers noting Mrs. Epstein's qualifications and flooded the convention with Florida orange stickers. Needless to say, the Floridians were delighted with the election results and believe Edie will represent our state with dignity and diplomacy.

Florida received an award for a 10% increase in membership and is now the third largest auxiliary in the nation. The FMA Auxiliary was also honored for the largest increase in members-at-large in the Southern Region.

In accordance with its primary aim of promoting optimum health for all Americans, the Auxiliary program emphasized the "Shape Up For Life" campaign and extended it through 1982. Workshops were held on Health Legislation, Food and Nutrition, Health Projects, Proper Exercise, Facing Death From A Child's Point Of View, AMA-ERF, and Membership, and a special seminar for state treasurers.

For the first time, the AMA Auxiliary has embraced the reference committee concept. Committee meetings were held on the morning of July 21, were well attended, and were enthusiastically received by the delegates.

The AMA Auxiliary House of Delegates, upon the recommendation of Reference Committee C, adopted a resolution proposed by the FMA Auxiliary encouraging the inclusion of a mini-will for organ donor designations to be provided on all drivers' licenses throughout the country. Such action is currently being implemented in Florida.

Guest speakers at the convention included Jessica Savitch, NBC news commentator; Letitia Baldridge, former White House social secretary; C. Carson Conrad, Executive Director of the President's Council on Physical Fitness and Health; and Hoyt Gardner, M.D., President of the AMA. The meeting updated auxilians on the problems and issues facing American medicine today, and suggested directions the Auxiliary should take to effectively aid in meeting these challenges.

Mrs. Fred P. Swing
President
Florida Medical Association
Auxiliary, Inc.

Editor's Note: Congratulations are in order for Mrs. Epstein on her recent election to the 1980-81 National Nominating Committee. Also of note is the fact that Mrs. Swing had a personal bonus at the Confab. Her brother's wife, Mrs. James Egan of Portland, Oregon attended the Auxiliary functions as president elect of the Oregon Medical Association Auxiliary.



Cerebro-Nicin®
CAPSULES

A gentle cerebral stimulant and vasodilator for the geriatric patient

Each CEREBRO-NICIN® capsule contains:
Pentylenetetrazole ..... 100 mg.
Nicotinic Acid ..... 100 mg.
Ascorbic Acid ..... 100 mg.
Thiamine HCL ..... 25 mg.
l-Glutamic Acid ..... 50 mg.
Niacinamide ..... 5 mg.
Riboflavin ..... 2 mg.
Pyridoxine HCL ..... 3 mg.
AVAILABLE: Bottles 100, 500, 1000

SIDE EFFECTS: Most persons experience a flushing and tingling sensation after taking a higher potency nicotinic acid. As a secondary reaction some will complain of nausea, sweating and abdominal cramps. The reaction is usually transient.

INDICATIONS: As a cerebral stimulant and vasodilator.

RECOMMENDED GERIATRIC DOSAGE: One capsule three times daily adjusted to the individual patient.

WARNING: Overdosage may cause muscle tremor and convulsions.

CONTRAINDICATIONS: Epilepsy or low convulsive threshold.

CAUTION: Federal law prohibits dispensing without prescription. Keep out of reach of children.

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REFER TO PDR

MEETINGS

Accepted by the FMA Committee on Continuing Medical Education for Mandatory Credit

OCTOBER

Advanced Cardiac Life Support Course, Oct. 3-4, Hollywood Medical Center, Hollywood. For information: Karen R. Craparo, M.D., Chief Emergency Room Physician, Hollywood Medical Center, 3600 Washington Street, Hollywood 33021.

A Symposium: Update in Bloodbanking, Oct. 10, Florida Junior College, North Campus Auditorium. For information: Dept. of Medical Laboratory Technology, Florida Junior College at Jacksonville, North Campus, Jacksonville 32218.

Echocardiography In-Service Workshop, Oct. 20-24, University of Miami, Jackson Memorial Medical Center, Miami.*

Sexual Problems in Everyday Practice, Oct. 29-30, Mount Sinai Medical Center, Miami Beach. For information: CME Office, Ronald H. Scheer, M.D., Mount Sinai Medical Center, 4300 Alton Road, Miami Beach 33140.

Quality Assurance Update, Including JCAH's New Quality Assurance Standards and PSRO's Quality of Patient Care Policy, Oct. 30-31, St. Joseph Hospital, Port Charlotte. For information: Edward J. Rupnik, M.D., 1549 State Street, Sarasota 33577.

21st Workshop in EKG for Nurses and Physicians, Oct. 30-Nov. 3, Sheraton Sand Key Hotel, Clearwater Beach. For information: Henry J. L. Mariott, M.D., St. Anthony's Hospital, St. Petersburg 33705.

NOVEMBER

Clinical Diabetes 1980, Nov. 1, Auditorium, University of South Florida College of Medicine, Tampa. For information: Brendan C. O'Malley, M.D., Box 45, 12901 N. 30th St., Tampa 33612.

Difficult Decisions in Cancer Management, Nov. 1, Holiday Inn, (Sarasota) Longboat Key. For information: S. P. Bralow, M.D., 1814 Hillview Street, Sarasota 33579.

Fourth Annual Suncoast Perinatal Conference, Nov. 7-8, Bayfront Medical Center, St. Petersburg. For information: Mrs. Pat Fowler, Bayfront Medical Center, 701 Sixth St. S., St. Petersburg 33701.

Vascular Lesion of CNS, Nov. 10, Citrus Memorial Hospital, Inverness. For information: R. Edward Dodge Jr., M.D., 511 W. Highland Blvd., Inverness 32650.

Sixth Annual Pan American Medical Seminar, (In Spanish), Nov. 10-14, Mount Sinai Medical Center, Miami Beach. For information: CME Office, Federico R. Justiniani, M.D., Mount Sinai Medical Center, 4300 Alton Road, Miami Beach 33140.

Hypertension Workshop, Nov. 13, Abbey Hospital Conference Room, Coral Gables. For information: Anthony J. Pellicane Sr., M.D., 5190 S.W. 8th St., Coral Gables 33134.

Clinical Management Testing of Coronary Disease and Exercise, Nov. 14-16, Orlando Hyatt, Kissimmee. For information: International Medical Education Corporation, Division of Postgraduate Education, Dept. 12, 64 Inverness Drive East, Englewood, Colorado 80112.

Hypertension Seminar, Nov. 15, Breckenridge Hotel, St. Petersburg Beach. For information: Walter Hamilton, M.D., 432 Pasadena Avenue, South, St. Petersburg 33707.

Intensive Review Course in Family Medicine, Nov. 17-21, Airport Holiday Inn, Tampa. For information: Charles E. Aucremann, M.D., USF Medical Center, Dept. of Family Medicine, Box 13, 12901 N. 30th Street, Tampa 33612.

DECEMBER

Basic Life Support (CPR), Dec. 2, University Community Hospital Conference Room, Tampa. For information: John E. Perchalski, M.D., 10320 North 56th Street, Suite G, Temple Terrace 33617.

Laparoscopy Techniques and Therapeutic Techniques, Dec. 3-5, Contemporary Resort Hotel, Walt Disney World, Lake Buena Vista. For information: H. Worth Boyce Jr., M.D., USF Medical Center, Box 19, 12901 North 30th Street, Tampa 33612.

JANUARY

25th Annual Cardiovascular Seminar, Jan. 9-10, Sarasota-Longboat Key Holiday Inn, Longboat Key. For information: Mr. E. Jerry Eatman, Executive Director, American Heart Association, Suncoast Chapter, Inc., Box 12407, St. Petersburg 33733.

13th Annual Postgraduate Seminar in Pediatric and Adult Urology, Jan. 21-24, Konover Hotel, Miami Beach. For information: Victor Politano, M.D., 6614 Miami Lakes Drive, East, Miami Lakes 33014.

8th Annual Symposium in Pediatric Nephrology: Current Concepts in Diagnosis and Management, Jan. 25-29, Sheraton-Bal Harbour, Bal Harbour. For information: Jose Strauss, M.D., Division of Pediatric Nephrology (R-131), Box 016960, Miami 33101.

19th Annual Seminar "Imageology 1981", Jan. 25-30, Sheraton Bal Harbour, Miami Beach. For information: Lucy R. Kelley, c/o Miami Seminars, Box 343762, Coral Gables 33134.

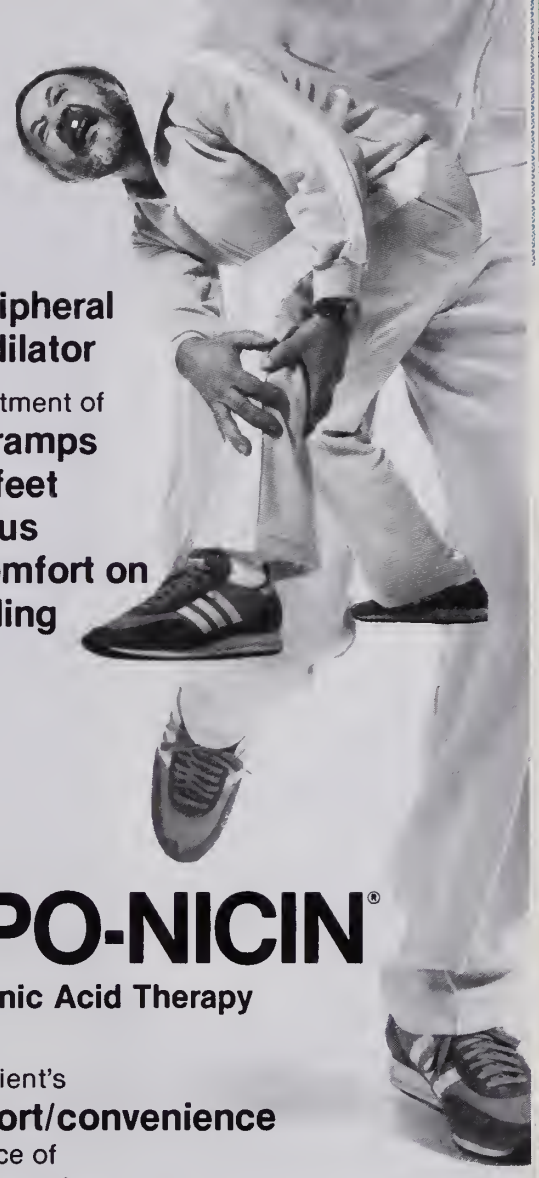
2nd Annual Seminar "Practical Approaches to Diagnostic Problems in Radiology", Jan. 30-Feb. 2, Dutch Inn, Lake Buena Vista. For information: Lucy R. Kelley, c/o Miami Seminars, Box 343762, Coral Gables 33134.

Florida Society of Pathologists Annual Slide Seminar, Jan.31-Feb. 1, Contemporary Building (Disney World), Lake Buena Vista. For informations: C.F. McConnell, M.D., 5151 N. Ninth Ave., Pensacola 32504.

***For information: Contact Division of Continuing Medical Education, D23-3, University of Miami School of Medicine, P.O. Box 016960, Miami 33101. Tel. (305) 547-6716.**

****For information: Contact Division of Continuing Education, Box J-233, J. Hillis Miller Health Center, Gainesville 32610. Tel. (904) 392-3143, or 392-3183.**

+For information: Contact Janifer M. Judisch, M.D., CME, University of South Florida, Tampa 33620. Tel. (813) 974-2196.



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Protein	100	100	80
Phosphorus	100	85	85
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Vitamin D	75	75	75
Niacin*	71	63	47
Thiamin	56	40	31
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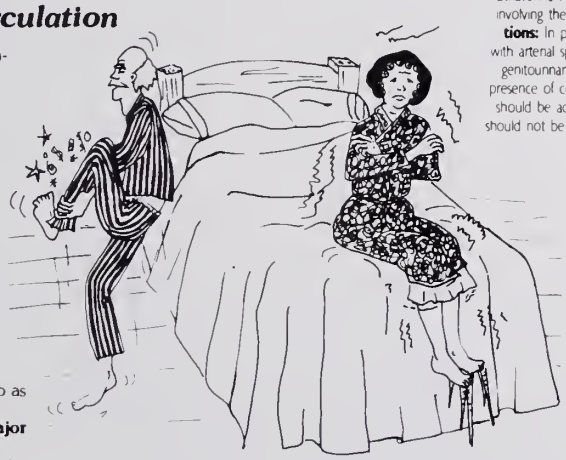
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* William J Oswald, M D . "Pharmacology of Ethavenne HCl" *Southern Medical Journal*, December 1975 - Vol 68, No 12



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Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

Pneumocystis carinii pneumonitis: Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets,* each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. *Tablets,* each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. *Oral suspension,* containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

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Please see reverse side for summary of product information.

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION INC

OCTOBER 1980 • VOL 67 • NO 10



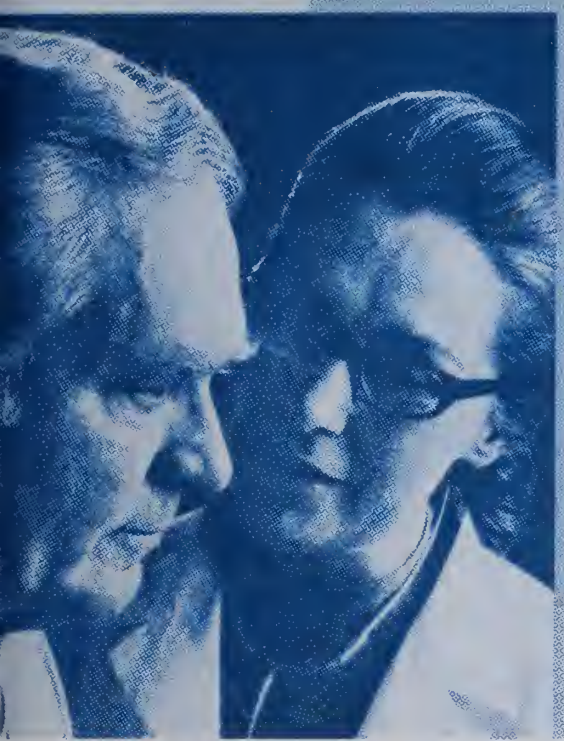
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Highly specific calming action virtually free of unwanted side effects: this was the remarkable clinical promise of Librium (chlordiazepoxide HCl). **And today this promise continues to be fulfilled in a wide variety of patients you see every day.**

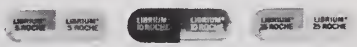
ROCHE



The published record on Librium is enormous. So large, in fact, it had to be put into a computer data bank and retrieval system. It's a record that shows Librium is highly effective in relieving anxiety; that Librium is seldom associated with serious side effects; that Librium rarely interferes with mental acuity at proper doses; that Librium is used concomitantly with primary medications. However, as with all CNS agents, patients should be warned against hazardous activities requiring complete alertness, and about possible combined effects with alcohol.

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Librium® ℞
chlordiazepoxide HCl/Roche



5mg, 10mg, 25mg capsules

synonymous with relief of anxiety

- ☐ An unsurpassed safety record
- ☐ Minimal effect on mental acuity, in proper dosage
- ☐ Predictable patient response
- ☐ Is used concomitantly with primary medications, such as anticholinergics and cardiovascular drugs

Please see next page for summary of product information.

Librium® 5mg, 10mg, 25mg capsules
chlordiazepoxide HCl/Roche

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral–Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d. Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

Supplied: Librium® (chlordiazepoxide HCl) *Capsules*, 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Libritabs® (chlordiazepoxide) *Tablets*, 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

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Cover

The new FMA Headquarters Office at 760 Riverside Avenue in Jacksonville is pictured on this month's cover. For more information about the new headquarters, as well as a little history about past locations of the headquarters, turn to page 944. Jacksonville artist Janet L. H. Grant created the artwork.

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Compared with the sublingual form, dosage administration is easier, with less need for supervision.

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How Supplied: Hydergine tablets (for oral use) 1 mg, packages of 100 and 500. **Hydergine sublingual tablets 1 mg,** containing dihydroergocornine mesylate 0.333 mg, dihydroergocristine mesylate 0.333 mg, and dihydroergocryptine (dihydro-alpha-ergocryptine and dihydro-beta-ergocryptine in the proportion of 2:1) mesylate 0.333 mg, representing a total of 1 mg; packages of 100, 500, and 1000. **Hydergine sublingual tablets 0.5 mg,** containing dihydroergocornine mesylate 0.167 mg, dihydroergocristine mesylate 0.167 mg, and dihydroergocryptine (dihydro-alpha-ergocryptine and dihydro-beta-ergocryptine in the proportion of 2:1) mesylate 0.167 mg, representing a total of 0.5 mg; packages of 100 and 1000.
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President's Page

The AMA and Florida

Several weeks ago I attended the annual AMA meeting in Chicago along with the other Florida AMA delegates, alternates, appropriate staff, and your Secretary Bob Windom, and our Editor Dan Nunn. As always, I was impressed with the amount of work done by your delegates in covering all the Reference Committees, interviewing all the candidates for political offices, and making all the daily 7:00 a.m. caucuses of the Florida Delegation. These conscientious individuals represent your interests exceedingly well and contribute greatly to the AMA far in excess of that expected for their number. Because of their individual capabilities and length of service in the House of Delegates they are very effective in promoting the interests of Florida physicians.

I am also impressed with the AMA. I don't mean that I agree with every action they take, but I have never seen a more democratic body. Every member who wishes to speak was heard at Reference Committee and again on the floor of the House of Delegates on any and every issue unless the House votes to terminate debate on an issue. The Reference Committee reports in general are excellent and their recommendations generally acceptable to the group but are certainly modified, rejected or referred for further study if the delegates don't agree with the recommendations. Specialty societies, students and residents as well as the state delegations are all represented.

The Florida doctors who belong to the AMA are reported to be less than 50% of the doctors practicing in Florida. We of the Florida delegation dispute the total active doctor figures in Florida from the AMA, but we all recognize that a significant number of Florida physicians do not belong to the AMA. We get one delegate for every 1,000 members or part thereof who belong to the AMA. At present, we have seven delegates and their alternates. This means we have between 6,000 and 7,000 AMA members in Florida. If we had approximately 600 more AMA members in the state, we would be over 7,000 members and entitled to another delegate and alternate.

I know all the excuses for not joining:

1. I don't agree with AMA and they don't do anything for me.
2. It costs too much.
3. They don't represent my views.
4. They have sold out to the government.
5. Etc.

I have been to too many AMA meetings and watched all the delegates in action to believe any of that, and I challenge any non-member to attend an AMA annual meeting, or the clinical meeting later this year in San Francisco and watch and participate in the meeting and see if you can honestly express any of the above excuses. Their actions are determined democratically by a majority of the delegates and most of the time you and I agree with their position. We don't agree 100% of the time (even you and I don't agree with our wives 100% of the time). However, when we do disagree, we can work to change their view — if we belong. The Florida delegates and Dr. Joseph Von Thron in particular did just that when we got the House of Delegates to pass Resolution 62 and changed the policy of AMA about introducing a National Health Insurance bill each year.

The FMA Auxiliary had an expression for it a few years ago which really said it all, "Join us — we can do more together."

T. Byron Thomas M.D.

FROM THE EDITOR'S DESK

PHYSICIANS ASKED TO WRITE "NO REFILL" ON PROPOXYPHENE PRESCRIPTIONS

In an attempt to help reduce propoxyphene abuse and deaths, FDA is requesting physicians to write "no refill" on prescriptions for the drug for patients who appear to need the drug for only a limited time. Although declining in numbers of incidents, propoxyphene is still a leading cause of drug associated deaths.

In ordering propoxyphene products (which include Darvon, Darvon-N, Darvocet-N, and other brand names and generics), physicians are cautioned against prescribing the drug for patients who are addiction prone; to use caution in prescribing the drug for patients taking antidepressant drugs and patients who use alcohol in excess; and to warn patients against exceeding the recommended dose and to limit their intake of alcohol.

INSECT STING KITS USEFUL - WITH WARNING

Emergency kits containing injectable epinephrine may save the life of someone at risk from the stings of Hymenoptera family insects (bees, yellow jackets, hornets and wasps) or with cross-reactivity to fire ant bites. The FDA encourages the prescription of such kits for patients at high risk with appropriate instruction in their use, but is opposed to over-the-counter sale of the kits due to the possibility of well-meaning misuse or deliberate abuse.

It is estimated that eight in every 1,000 people are allergic to insect stings and half of these are severely sensitive. It is difficult to predict the potential sensitivity of any particular patient, but an individual or family history of sensitivitiy to insect stings, as well as other allergens, can identify some of those at higher risk.

OUTBREAK OF DISEASE REPORTED ASSOCIATED WITH UNCOOKED SEAFOOD

Although not considered a serious public health threat, there have been reports of recent outbreaks of disease in Florida associated with the eating of raw oysters. Patients presenting with diarrhea may have acquired their illnesses from a non-O group 1 Vibrio cholerae (NAG) associated with raw seafood from a wide range of waters.

The FDA recommends that after a food history is taken from adult patients presenting with serious diarrhea, the patient's blood and stool should be examined for vibrio organisms. Thiosulfate citrate bile salts (TCBS) agar should be used because V. cholerae is not usually detected by standard analytical methods for common enteric bacterial pathogens.

AMA SEEKS FEDERAL OPINION ON CHIROPRACTIC

The AMA will ask the federal government to make "an independent and impartial study to evaluate the efficacy and safety of chiropractic." The House of Delegates in July adopted a resolution calling for the study. Lowell H. Steen, M.D., Chairman of the Board of Trustees, told a news conference that a study to determine "once and for all whether or not and under what medical circumstances chiropractic is effective and safe" would be "a great service to the American people." AMA EVP James H. Sammons, M.D., said, "The AMA, of course, cannot conduct such a study without bias. So let the federal government do it. If it turns out well for them, so be it. If it doesn't turn out well for them, so be it."

THC RESEARCH ENDORSED BY AMA

Research on the use of THC, the active ingredient in marijuana, to reduce nausea due to chemotherapy should be pursued in broader clinical trials with cancer patients, the AMA said in a letter to the FDA's Oncology Advisory Committee. The Association commended the efforts to bring "some hope of relief from the mentally and physically debilitating side effects of cancer chemotherapy" and offered assistance with expanded clinical trials. However, the letter urged continued stringent controls to avoid illicit use of the drug.

DEAN SEARCH EVALUATION SESSIONS CLOSED

The University of Florida College of Medicine and the College of Veterinary Medicine will close evaluation sessions to the public in the search to replace their deans. The chairmen of the search committees for both colleges said the searches themselves will be open but the meetings in which the candidates are assessed will be closed.

Circuit Judge R. A. "Buzzy" Green opened similar evaluation sessions in the College of Law's search for a new dean last May following a request for a temporary injunction. The suit, challenging the closed evaluative sessions as violative of the Sunshine Law, still is pending.

Noting that many of the candidates are UF employees, UF Public Information Officer Hugh Cunningham said, "We are required by law to protect confidentiality of evaluative material of employees."

DRUG ABUSE ON THE INCREASE

Illicit drug use has increased sharply in the past 20 years, according to two studies for the government which show that between 1972 and 1979 experience with marijuana and cocaine has doubled among young teenagers and among those over 25 years of age. Between ages 18 and 25, cocaine use has tripled and marijuana use has increased from 48 percent to 68 percent.

The proportion of people who have used marijuana has increased from four percent to 68 percent. Harder drugs--cocaine, heroin, hallucinogens, or inhalants--have been tried by 33 percent of 18 to 25 year-olds.

NO REIMBURSEMENT FOR SOME DRUGS

Legislation was introduced in the House to prohibit federal reimbursement under the Medicaid program for drugs that have not been found effective by the Food and Drug Administration. Rep. Bob Eckhardt (Dem. - Texas), Chairman of the House Commerce Subcommittee on Oversight, said as much as $400 million has been "wasted" over the past 10 years on drugs.

AMENDMENT TO FUND REYE'S SYMDROME RESEARCH PASSES HOUSE

The House of Representatives has approved an amendment to the Health Research Act of 1980 by U.S. Rep. C. W. Bill Young (R-Fla.) that will establish a coordinating committee in the National Institute of Health to conduct research for Reye's Syndrome, a child killing disease that claimed the lives of 66 young Americans last year.

The 66 that died were reported deaths. However, since Reye's Syndrome is not a reportable disease and since so little is known about it, there may have been many more children who died as a result of Reye's Syndrome.

The amendment will authorize funding for the establishment of a Reye's Syndrome Coordinating Committee and to establish two comprehensive Reye's Syndrome diagnostic and treatment centers. The amendment will also authorize the Coordinating Committee to provide for research grants each year to public agencies, non-profit private entities and individuals not associated with the centers.

HCFA RULE CHANGE

The Health Care Financing Administration (HCFA) finally realized that if hospitals are forced to deduct funds received under the federal grants from their Medicare reimbursement, the grants are of no benefit. So on August 5, HCFA published a final rule that reverses existing policy of deducting educational grants for the costs of primary care internship and residency programs for the purposes of figuring Medicare payments. The stated intent of this rule is to avoid nullifying the purposes of the educational grants.

ADMINISTRATION'S GUIDELINES COMPATIBLE WITH VE GOAL

The 1980 voluntary hospital expenditure guidelines announced recently by the Administration are compatible with the 1980 goal set by the health care industry last December, according to Paul W. Earle, Executive Director of the Voluntary Effort to Contain Health Care Costs (VE).

Last December the VE announced a 1980 goal of a 1.5 percentage point slowdown in the rate of increase in hospital inpatient expenditures. The Administration's goal is a 1.7 percentage point slowdown in the rate of increase in total hospital expenditures. Both goals are to be adjusted for changes in inflation.

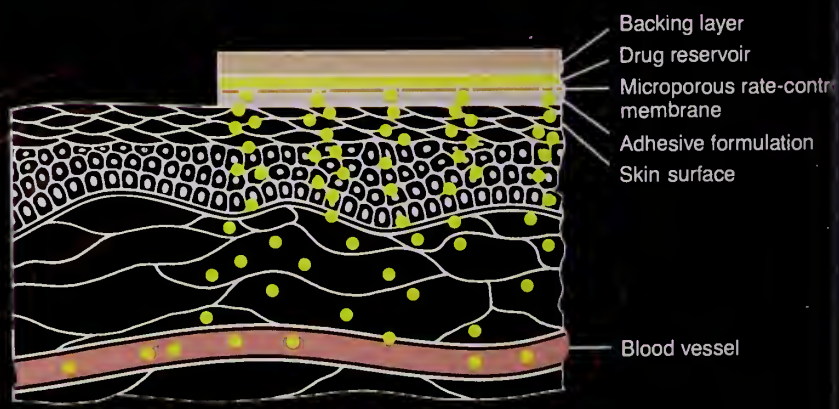
The Editor


Ruth Austin isn't
aking medication.
She's wearing it.

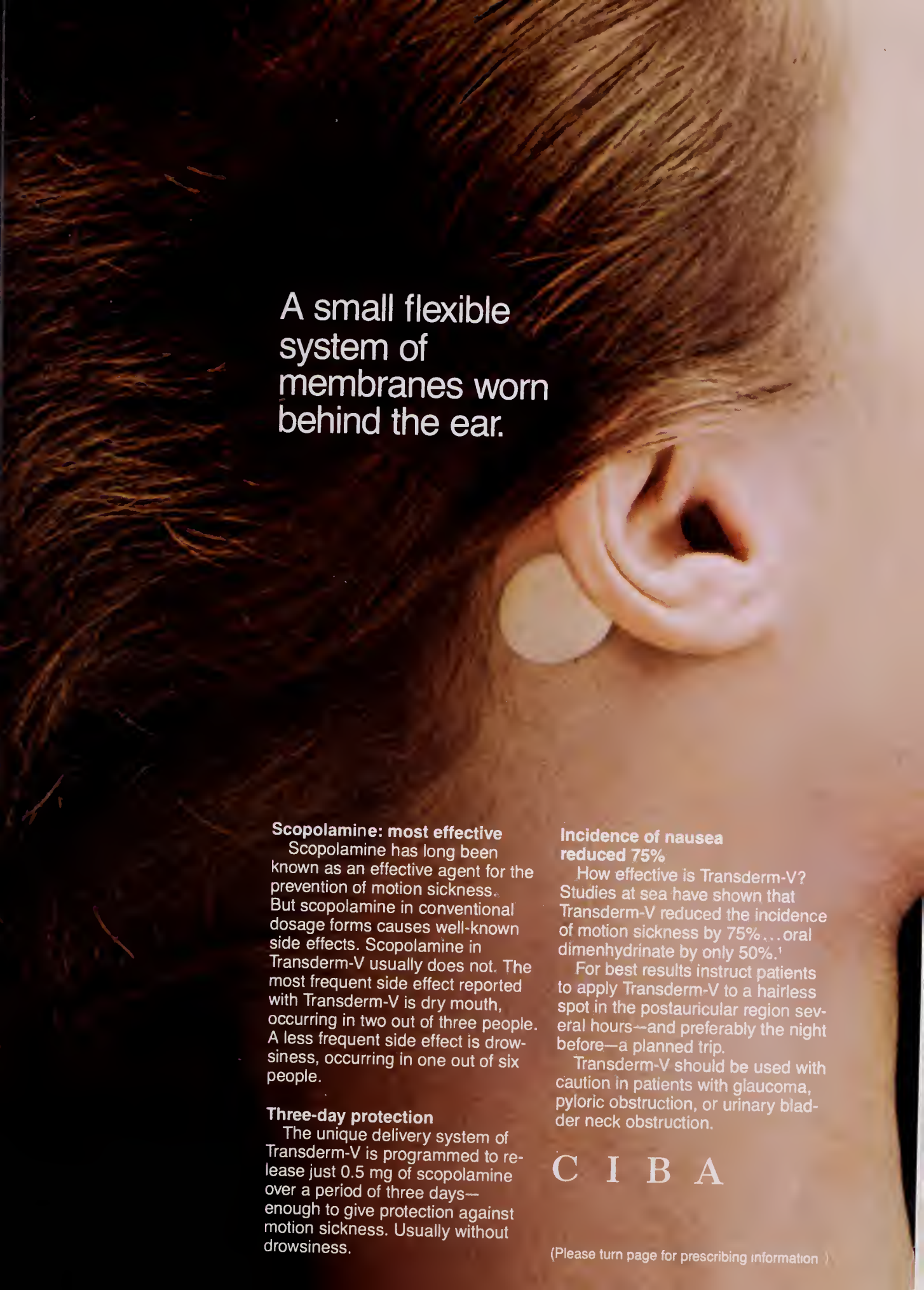
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motion sickness



Schematic drawing showing cross section of skin surface with Transderm-V in place and delivery of scopolamine to blood vessels.



A small flexible system of membranes worn behind the ear.

Scopolamine: most effective

Scopolamine has long been known as an effective agent for the prevention of motion sickness. But scopolamine in conventional dosage forms causes well-known side effects. Scopolamine in Transderm-V usually does not. The most frequent side effect reported with Transderm-V is dry mouth, occurring in two out of three people. A less frequent side effect is drowsiness, occurring in one out of six people.

Three-day protection

The unique delivery system of Transderm-V is programmed to release just 0.5 mg of scopolamine over a period of three days—enough to give protection against motion sickness. Usually without drowsiness.

Incidence of nausea reduced 75%

How effective is Transderm-V? Studies at sea have shown that Transderm-V reduced the incidence of motion sickness by 75%...oral dimenhydrinate by only 50%.[1]

For best results instruct patients to apply Transderm-V to a hairless spot in the postauricular region several hours—and preferably the night before—a planned trip.

Transderm-V should be used with caution in patients with glaucoma, pyloric obstruction, or urinary bladder neck obstruction.

CIBA

(Please turn page for prescribing information)

Transderm™-V
scopolamine

Transdermal
Therapeutic System

No highs or lows of plasma concentrations

Because transdermal administration eliminates the relatively high concentrations of drug that follow oral and intramuscular administration, the undesirable pharmacologic effects associated with high drug levels are usually avoided. Yet an effective therapeutic dosage is achieved and maintained—for 72 hours.

Reference
1. Price N, Schmitt LG, Shaw JE, Trobough T, McGuire J. Transdermal delivery of scopolamine for prevention of motion-induced nausea at sea. Data on file, ALZA Corporation, California.

CIBA

Transderm™-V
(scopolamine)

Transdermal Therapeutic System

Programmed delivery *in vivo* of 0.5 mg scopolamine over 3 days

Description Transderm™-V scopolamine system is a circular flat unit designed for continuous release of scopolamine following application to an area of intact skin on the head, behind the ear. Clinical evaluation has demonstrated that the system provides effective antiemetic and antinauseant actions when tested against motion-sickness stimuli in adults.

The Transderm™-V system is a 0.2 mm thick film, with four layers. Proceeding from the visible surface towards the surface attached to the skin, these layers are: 1) a backing layer of aluminized polyester film; 2) a drug reservoir of scopolamine, mineral oil, and polyisobutylene; 3) a microporous polypropylene membrane that controls the rate of delivery of scopolamine from the system to the skin surface; and 4) an adhesive formulation of mineral oil, polyisobutylene, and scopolamine. Prior to use, a protective peel strip of siliconized polyester which covers layer 4 is removed.

The mineral oil (12.4 mg) and polyisobutylene (11.4 mg) inactive components are not released from the system.

Release Rate Concept: Transderm™-V system, 2.5 cm^2 in area, contains 1.5 mg scopolamine. The system is programmed to deliver 0.5 mg scopolamine, at an approximately constant rate to the systemic circulation, over the 3-day lifetime of the system. An initial priming dose of scopolamine released from the adhesive layer of the system, saturates the skin binding sites for scopolamine and rapidly brings the plasma concentration to the required steady state level. The continuous controlled release of scopolamine, that follows from the drug reservoir through the rate controlling membrane, then maintains the plasma level constant.

Clinical Pharmacology The formulation of the Transderm™-V system contains as its sole active agent the drug scopolamine, a belladonna alkaloid with well-known pharmacological properties. The drug has a long history of oral and parenteral use for central anticholinergic activity, including prophylaxis of motion sickness. This formulation provides for a gradual release of scopolamine from an adhesive matrix of mineral oil and polyisobutylene applied to the postauricular skin.

Clinical Results: The Transderm™-V system provides antiemetic protection within several hours following application of the system behind the ear. With the 195 adult subjects of different racial origins who participated in clinical efficacy studies at sea or in a controlled motion environment, there was a 75% reduction in the incidence of motion-induced nausea and vomiting. The Transderm™-V system provided significantly greater protection than that obtained with oral dimenhydrinate.

Indications and Usage The Transderm™-V system is indicated for prevention of nausea and vomiting associated with motion sickness in adults. The system should be applied only to skin in the postauricular area.

Contraindications Transderm™-V system should not be used in patients with known hypersensitivity to scopolamine or any of the components of the adhesive matrix making up the therapeutic system.

Warnings Since drowsiness, disorientation and confusion may occur with the use of scopolamine, patients should be warned of the possibility and cautioned against engaging in activities that require mental alertness, such as driving a motor vehicle or operating dangerous machinery.

Potentially alarming idiosyncratic reactions may occur with ordinary therapeutic doses of scopolamine.

Usage in Children: Children are particularly susceptible to the side effects of belladonna alkaloids. Transderm™-V system should not be used in children because it is not known whether this system will release an amount of scopolamine that could produce serious adverse effects in children.

Precautions Scopolamine should be used with caution in patients with glaucoma, pyloric obstruction, or urinary bladder neck obstruction. Caution should be exercised when administering an antiemetic or antimuscarinic drug to patients suspected of having intestinal obstruction.

Pregnancy: Reproductive studies have been performed in rats and rabbits and have revealed no evidence of impaired fertility or harm to the fetus due to scopolamine administered, with plasma levels in excess of those attained by use of the Transderm™-V system in humans. However, the Transderm™-V system should be used in pregnant women with motion sickness only when clearly needed.

Nursing Mothers: It is not known whether scopolamine is excreted in human milk. As a general rule, nursing should not be undertaken while a patient is on a drug since many drugs are excreted in human milk.

Adverse Reactions The most frequent adverse reaction to the Transderm™-V system is dryness of the mouth. This occurs in about two-thirds of the people. A less frequent adverse reaction is drowsiness, which occurs in less than one-sixth of the people. Transient impairment of eye accommoda tion is also observed. The following adverse rea tions have also been reported on infrequent occ sions during use of the Transderm™-V system: c orientation, memory disturbances, restlessness giddiness, hallucinations and confusion.

Overdosage Overdosage with scopolamine ma cause disorientation, memory disturbances, res lessness, giddiness, hallucinations or confusion Should these symptoms occur, the Transderm™ system should be immediately removed. Appro ate parasympathomimetic therapy should be ini tiated if these symptoms are severe.

Dosage and Administration *Adults: Initiation Therapy:* One Transderm™-V system, programr to deliver 0.5 mg scopolamine over three days, should be applied to the postauricular skin seve hours before the antiemetic effect is required.

Handling: The hands should be washed and dri thoroughly before applying the system on dry sk behind the ear. Upon removal of the system it should be discarded and the hands and applica site washed thoroughly to prevent any traces of scopolamine from coming into direct contact wit the eyes. A patient brochure is available.

Continuation of Therapy: Should a system bec displaced, it should be removed and replaced w second system on a fresh skin site in the postau lar area. If therapy is required for longer than 72 hours, the first system should be removed and a second system placed on a fresh skin site in the postauricular area.

Children: Children are particularly susceptible t side effects of belladonna alkaloids. Transderm system should not be used in children because not known whether this system will release an amount of scopolamine that could produce seri adverse effects in children.

How Supplied Transderm™-V systems are ava able in 2-unit blister packs.

Storage and Handling The system should be stored at room temperature.

Caution Federal law prohibits dispensing witho prescription.

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WHEN ANXIETY AND TENSION MAGNIFY PAIN

IN MUSCULOSKELETAL DISEASE*

A non-narcotic one-two punch against pain, with concurrent relief of anxiety/tension

EQUAGESIC® ℞

(meprobamate and ethoheptazine citrate with aspirin) Wyeth

EQUAGESIC—Abbreviated Summary

***INDICATIONS:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows

"Possibly" effective for the treatment of pain accompanied by tension and/or anxiety in patients with musculoskeletal disease or tension headache.

Final classification of the less-than-effective indications requires further investigation.

The effectiveness of Equagesic in long-term use, i.e. more than four months, has not been assessed by systematic clinical studies. The physician should periodically reassess usefulness of the drug for the individual patient.

CONTRAINDICATIONS: Equagesic should not be given to individuals with a history of sensitivity or severe intolerance to aspirin, meprobamate, or ethoheptazine citrate

WARNINGS: Careful supervision of dose and amounts prescribed for patients is advised, especially with those patients with known propensity for taking excessive quantities of drugs Excessive and prolonged use in susceptible persons, e.g., alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on or habituation to the drug Where excessive dosage has continued for weeks or months, dosage should be reduced gradually rather than abruptly stopped, since withdrawal of a "crutch" may precipitate withdrawal reaction of greater proportions than that for which the drug was originally prescribed Abrupt discontinuance of doses in excess of the recommended dose has resulted in some cases in the occurrence of epileptiform seizures

Special care should be taken to warn patients taking meprobamate that tolerance to alcohol may be lowered with resultant slowing of reaction time and impairment of judgement and coordination

USAGE IN PREGNANCY AND LACTATION: An increased risk of congenital malformations associated with the use of minor tranquilizers (meprobamate, chlordiazepoxide, and diazepam) during the first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a women of child-bearing potential may be pregnant at the time of institution of therapy should be considered. Patients should be advised that if they become pregnant during therapy or intend to become pregnant they should communicate with their physicians about the desirability of discontinuing the drug.

Meprobamate passes the placental barrier. It is present both in umbifical-cord blood at or near maternal plasma levels and in breast milk of lacteting mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breast-feeding patients, the drug's higher concentrations in breast milk as compared to maternal plasma levels should be considered.

Preparations containing aspirin should be kept out of the reach of children Equagesic is not recommended for patients 12 years of age and under

PRECAUTIONS: Should drowsiness, ataxia, or visual disturbance occur, the dose should be reduced If symptoms continue, patients should not operate a motor vehicle or any dangerous machinery

Suicidal attempts with meprobamate have resulted in coma, shock, vasomotor and respiratory collapse, and anuria Very few suicidal attempts were fatal, although some patients ingested very large amounts of the drug (20 to 40 gm) These doses are much greater than recommended The drug should be given cautiously, and in small amounts, to patients who have suicidal tendencies In cases where excessive doses have been taken, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels Hyperventilation has been reported occasionally Any drug remaining in the stomach should be removed and symptomatic treatment given Should respiration become very shallow and slow, CNS stimulants, e.g., caffeine, Metrazol, or amphetamine, may be cautiously administered If severe hypotension develops, pressor amines should be used parenterally to restore blood pressure to normal levels

ADVERSE REACTIONS: A small percentage of patients may experience nausea with or without vomiting and epigastric distress Dizziness occurs rarely when meprobamate and ethoheptazine citrate with aspirin is administered in recommended dosage The meprobamate may cause drowsiness but, as a rule, this disappears as therapy is continued Should drowsiness persist and be associated with ataxia, this symptom can usually be controlled by decreasing the dose, but occasionally it may be desirable to administer central stimulants such as amphetamine or mephentermine sulfate concomitantly to control drowsiness

A clearly related side effect to the administration of meprobamate is the rare occurrence of allergic or idiosyncratic reactions This response develops, as a rule, in patients who have had only 1-4 doses of meprobamate and have not had a previous contact with the drug Previous history of allergy may or may not be related to the incidence of reactions

Mild reactions are characterized by an itchy urticarial or erythematous, maculopapular rash which may be generalized or confined to the groin Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema, and fever have also been reported

More severe cases, observed only very rarely, may also have other allergic responses, including fever, fainting spells, angioneurotic edema bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case), and hyperthermia Treatment should be symptomatic such as administration of epinephrine, antihistamine, and possibly hydrocortisone Meprobamate should be stopped, and reinstitution of therapy should not be attempted

Rare cases have been reported where patients receiving meprobamate suffered from aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia In nearly every instance reported, other toxic agents known to have caused these conditions have been associated with meprobamate A few cases of leukopenia during continuous administration of meprobamate are reported, most of these returned to normal without discontinuation of the drug

Impairment of accommodation and visual acuity has been reported rarely

OVERDOSE: Two instances of accidental or intentional significant overdosage with ethoheptazine citrate combined with aspirin have been reported These were accompanied by symptoms of CNS depression, including drowsiness and light-headedness, with uneventful recovery However, on the basis of pharmacological data, it may be anticipated that CNS stimulation could occur Other anticipated symptoms would include nausea and vomiting Appropriate therapy of signs and symptoms as they appear is the only recommendation possible at this time Overdosage with ethoheptazine combined with aspirin would probably produce the usual symptoms and signs of salicylate intoxication Observation and treatment should include induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs usually requires whole-blood transfusions

DESCRIPTION: Each Equagesic tablet contains 150 mg meprobamate, 75 mg ethoheptazine citrate and 250 mg aspirin

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*This drug has been evaluated as possibly effective for this indication.

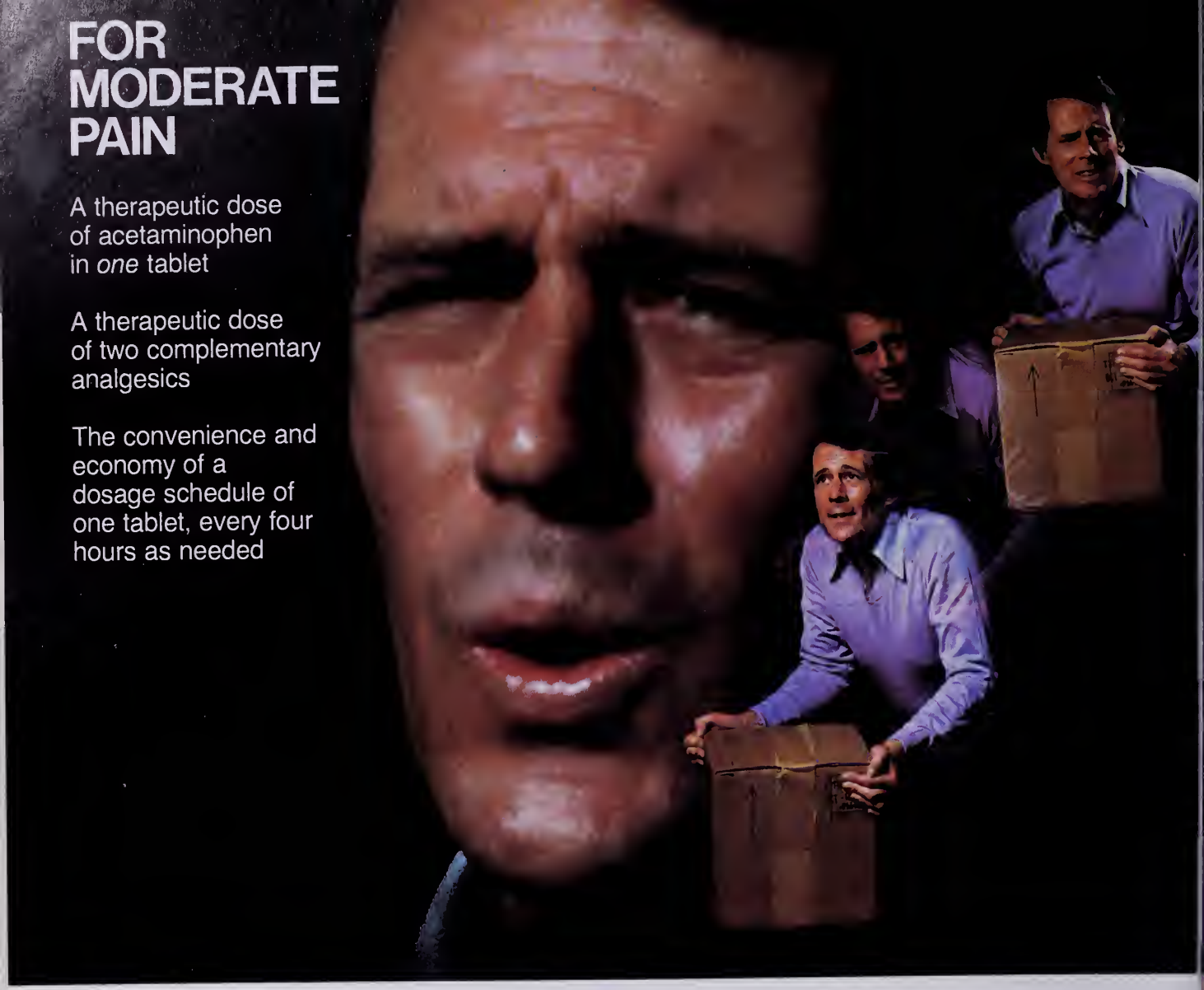
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FOR MODERATE PAIN

A therapeutic dose of acetaminophen in *one* tablet

A therapeutic dose of two complementary analgesics

The convenience and economy of a dosage schedule of one tablet, every four hours as needed



WHY NOT WYGESIC®

(65 mg propoxyphene HCl and 650 mg acetaminophen) Wyeth

WYGESIC—Abbreviated Summary
INDICATION: For the relief of mild-to-moderate pain.
CONTRAINDICATION: Hypersensitivity to propoxyphene or to acetaminophen
WARNINGS: CNS ADDITIVE EFFECTS AND OVERDOSAGE Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, or other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. Toxic effects and fatalities have occurred following overdoses of propoxyphene alone or in combination with other CNS depressants. Most of these patients had histories of emotional disturbances or suicidal ideation or attempts, as well as misuse of tranquilizers, alcohol, or other CNS-active drugs. Caution should be exercised in prescribing large amounts of propoxyphene for such patients (see **Management of Overdosage**).
DRUG DEPENDENCE: Propoxyphene can produce drug dependence characterized by psychic dependence and less frequently, physical dependence and tolerance. It will only partially suppress the withdrawal syndrome in individuals physically dependent on morphine or other narcotics. The abuse liability of propoxyphene is qualitatively similar to codeine's although quantitatively less, and propoxyphene should be prescribed with the same degree of caution appropriate to the use of codeine
USAGE IN AMBULATORY PATIENTS: Propoxyphene may impair the mental and/or physical abilities required for potentially hazardous tasks, e.g. driving a car or operating machinery. Patients should be cautioned accordingly
USAGE IN PREGNANCY: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. INSTANCES OF WITHDRAWAL SYMPTOMS IN THE NEONATE HAVE BEEN REPORTED FOLLOWING USAGE DURING PREGNANCY. Therefore, propoxyphene should not be used in pregnant women unless, in the judgement of the physician, the potential benefits outweigh the possible hazards.
USAGE IN CHILDREN: Propoxyphene is not recommended for children because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric group.
PRECAUTIONS: Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine. The CNS depressant effect of propoxyphene may be additive with other CNS depressants, including alcohol.
ADVERSE REACTIONS: The most frequent adverse reactions are dizziness, sedation, nausea, and vomiting. These seem more prominent in ambulatory than in nonambulatory patients; some of these reactions may be alleviated if the patient lies down.
Other adverse reactions include constipation, abdominal pain, skin rashes, light-headedness, headache, weakness, euphoria, dysphoria, and minor visual disturbances. The chronic ingestion of propoxyphene in doses over 800 mg per day has caused toxic psychoses and convulsions. Cases of liver dysfunction have been reported.
DRUG INTERACTIONS: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, and other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. (see **Warnings**)
Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine
MANAGEMENT OF OVERDOSAGE: SYMPTOMS
The manifestations of serious overdosage with propoxyphene are similar to those of narcotic overdosage and include respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, pupillary constriction, and circulatory collapse. In addition to these characteristics, which are reversed by narcotic antagonists such as naloxone, there may be other effects. Overdoses of propoxyphene can cause delay of cardiac conduction as well as focal or generalized convulsions, a prominent feature in most cases of severe poisoning. Cardiac arrhythmias and pulmonary edema have occasionally been reported, and apnea, cardiac arrest, and death have occurred.
Symptoms of massive overdosage with acetaminophen may include nausea, vomiting, anorexia, and abdominal pain, beginning shortly after ingestion and lasting for 12 to 24 hours. However, early recognition may be difficult since early symptoms may be mild and nonspecific. Evidence of liver damage is usually delayed. After the initial symptoms, the patient may feel less ill; however, laboratory determinations are likely to show a rapid rise in liver enzymes and bilirubin. In case of serious hepatotoxicity, jaundice, coagulation defects, hypoglycemia, encephalopathy, coma, and death may follow. Renal failure due to tubular necrosis, and myocardiopathy, have also been reported.
Ingestion of 10 grams or more of acetaminophen may produce hepatotoxicity. A 13-gram dose has reportedly been fatal.
TREATMENT: Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation. The narcotic antagonists, naloxone, nalorphine, and levallorphan, are specific antidotes against the respiratory depression produced by propoxyphene. An appropriate dose of one of these antagonists should be administered, preferably IV, simultaneously with efforts at respiratory resuscitation and the antagonist should be repeated as necessary until the patient's condition remains satisfactory. In addition to a narcotic antagonist, the patient may require careful titration with an anticonvulsant to control seizures. Analeptic drugs (e.g. caffeine or amphetamine) should not be used because of their tendency to precipitate convulsions.
Oxygen, IV fluids, vasopressors and other supportive measures should be used as indicated. Gastric lavage may be helpful. Activated charcoal can absorb a significant amount of ingested propoxyphene.
Dialysis is of little value in poisoning by propoxyphene alone. Acetaminophen is rapidly absorbed, and efforts to remove the drug from the body should not be delayed. Copious gastric lavage and or induction of emesis may be indicated. Activated charcoal is probably ineffective unless administered almost immediately after acetaminophen ingestion. Neither forced diuresis nor hemodialysis appears to be effective in removing acetaminophen. Since acetaminophen in overdose may have an antidiuretic effect and may produce renal damage, administration of fluids should be carefully monitored to avoid overload. It has been reported that mercaptamine (cysteamine) or other thiol compounds may protect against liver damage if given soon after overdosage (8-10 hours). N-acetylcysteine is under investigation as a less toxic alternative to mercaptamine, which may cause anorexia, nausea, vomiting, and drowsiness. Appropriate literature should be consulted for further information. (JAMA 237:2406-2407, 1977)
Clinical and laboratory evidence of hepatotoxicity may be delayed up to one week. Acetaminophen plasma levels and half-life may be useful in assessing the likelihood of hepatotoxicity. Serial hepatic enzyme determinations are also recommended

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Editorials

New Hope for Children with Leukemias

S. A. Delamerens, M.D.

The control of infectious diseases by preventive measures and antibiotic therapy has turned children's cancer into the leading cause of death, exceeded only by accidents.

Childhood cancer represents a difficult socio-economic and medical problem. Even with the improvement in diagnostic and therapeutic measures observed in the past ten years, a large proportion of children still succumb to malignant diseases. This fact demonstrates the necessity of stronger efforts to find the cure for cancer and to minimize the suffering by providing better facilities for diagnosis and treatment.

In this issue the article by Paulette Mehta, M.D., depicts new developments in the management of acute lymphocytic leukemia in children. Most significant is that in our environment, by using similar protocols, we have obtained similar or better results as compared to other leading national pediatric oncology groups.

There are important differences between adults and children with malignant diseases. Diagnostic approach, tissue-organ involved, relative incidence of different tumors, severity of the disease process with a type of tumor, treatment schedules and response to treatment are among these differences. Tumors of the same organ systems may have different prognoses in the two age groups, perhaps because of differences in biologic characteristics. It is known that acute lymphocytic leukemia is more prominent in children, and therapeutic results are better than in adults. Conversely, in acute myelocytic leukemia, seen more frequently in adults, only 30% to 35% of patients respond to current chemotherapy with a rather short initial remission.

Longer periods in which patients appear to be free of disease are now possible. This is true when early diagnosis and modern treatment schedules have been made, usually in medical centers equipped with the best diagnostic and therapeutic facilities and with medical and paramedical staffs especially skilled in these disciplines.

For these reasons, specialized expertise is necessary for the management of all aspects of childhood cancer. The average practicing physician has limited exposure to these conditions since the incidence of malignancies in children is far less than in adults. Therefore, it is generally agreed that childhood cancer should have a special pediatric oncology management inherent to the peculiarities of these processes in children.

Since these patients are suffering from a disease that may involve different organs, a "total care" concept should be instituted. In addition to regular pediatric hematology and oncology care, pathology, radiology and radiotherapy, special consultations with leading specialists in pediatric surgery, neurosurgery, ophthalmology, orthopedics, immunology, endocrinology, nephrology, pharmacology, ENT, and dentistry should also be provided.

These facilities are usually available in specialized pediatric hospitals. Using appropriate "protocols" for treatment, it is possible nowadays to obtain the best results and to accumulate important data for improvement of future therapeutic regimes.

The type of care these patients need is extremely expensive, according to present economic trends. This results in an economic burden not only to the middle class, who constitute the majority of patients, but also to the affluent. Most of the time, these groups are not eligible for charity or government-sponsored health insurance programs.

There is reluctance on the part of some young physicians to specialize in pediatric oncology. Being exposed to a well-organized pediatric hematology and oncology center, the young pediatrician may be motivated to enter into this specialty. Also, a center of such nature should have teaching responsibilities with the medical and paramedical resources within its own community.

It may be anticipated that by the intelligent use of therapeutic improvements derived from the use of research protocols, childhood leukemia will become a more manageable disease than it is nowadays.

The Author

S. A. DELAMERENS

Dr. Delamerens is Director of the Division of Hematology and Oncology at Variety Children's Hospital in Miami.

● Dr. Delamerens, Variety Children's Hospital, Miami 33155.

The Roles of A Journal

A journal of a state medical association is a means of communicating with its fellow members. It is a medium for reporting scientific, medical, socio-economic and legal news and the offering of intelligent opinion in the market place of ideas.

Analysis of the roles of a state journal should be a factor of major importance to every physician. A journal is more than a place to share your clinical observations and experiences with your colleagues.

A journal also places emphasis on the political, economic and social trends of the times as they correlate with medicine. This interaction with its influences benefits both physicians and their patients.

Some physicians advocate that state journals become more activist and challenging, particularly in covering politics and government as it relates to the medical profession. These advocates claim that the American press, powerful as it unquestionably is and protected though it may be by the Constitution and laws is usually more anxious for profitability than respectability.

There are physicians that advocate robust and uninhibited opposition in the journals to the long-established practice of damaging the American physician's image and his fee for service practice by slanted news reports, distorted commentaries and even outright falsehoods.

The interpretive reporting of a state medical journal should not be through emotions but rather through reason. A truly good journal holds truth — unattainable and frequently plural as it is — as its highest value and knowledge as its first responsibility.

State journals play an important role in the increasingly complex area of continuing medical education. Journals should be indefatigable seekers of truth in medical journalism. Ethics of objective journalism require that every effort be made to get "both sides of the story."

Every medical writer engages in an increasing amount of self-analysis as he realizes that partisanship in scientific or editorial comment which knowingly departs from the truth does violence to the best spirit of American journalism.

The editorial chair of *The Journal of the Florida Medical Association* gives not only the editorial board but every member an opportunity for variety of expression of opinions.

This *Journal* invites intelligent discussion from all shades of opinions in its "letters to the editor" column. Physicians will be surprised that they often possess literary talent that enables them to touch chords of humor and pathos and to rise to occasional levels of literary beauty. Physicians are often unexcelled in forcible expression of logically developed opinions.

It is my belief that a state medical journal should be a sanctuary of knowledge, truth and tolerance of the opinions and actions of others. A physician's mind is always supple and ready to receive knowledge. A journal can add depth and breadth to one's knowledge by providing an increasingly solid link with the provocative minds and spirits of the past and present.

Editorials in the state journals of medical associations should shake up the staid ranks of the membership and keep hammering away at shortcomings with zest.

Edward Pedrero Jr., M.D.
Assistant Editor
Tampa

A Former Medical Student Activist's Look at the AMA

It has been eight years since I last attended an annual meeting of the American Medical Association. This Summer I returned to Chicago, the city where I attended Medical School, and the home of the policy-making, AMA House of Delegates' annual meeting. Many things about the meeting have remained the same but, like life itself, much has changed.

I can remember the Atlantic City annual meeting in 1971 quite well. I was just starting my fourth year in medical school and had recently been elected National Treasurer of the Student American Medical Association, now known as the American Medical Student Association. The scientific exhibits overflowed the Atlantic City Convention Hall. My wife and I joked as she walked onto the deserted stage that this is the closest she would ever come to being Miss America. The huge scientific program overshadowed the political portion of the meeting. In fact, most of the physicians attending the meeting had no involvement in the political process, whatsoever. Scientific programs in every specialty were held in the massive convention center while the delegates met at the hotel. In the evenings, the small band of students in attendance would move from one hospitality suite to another, gathering support for their issues. Students were limited to $5.00 per day for food, so most dinners consisted of pretzels and chips, while talking with delegates. Due to AMA financial problems and dwindling attendance at annual meetings, the scientific exhibits and programs are now gone so that now only the politics remain. In 1965, over 64,000 people, including 24,000 physicians attended the AMA's annual session in New York. Last year about 1,700 people attended the annual meeting in Chicago. With physicians looking more and more toward the own specialty society (AAFP, ACP, ACS, etc.) for their continuing medical education, attendance at AMA scientific sessions has fallen. Thus, the AMA was forced to change from a predominantly scientific professional organization to the role of medicine's political spokesman.

I was glad to see that the hospitality of the delegates and officers had not changed in nine years. I was not an official delegate in Chicago, but was accepted as an equal, not only by our Florida Delegation, but by other physicians as well. During the late 1960's and early 70's, as a medical student and later house officer, I attended about seven AMA meetings. I was also a member of the AMA House Staff Affairs Committee, in 1974. At that time, the relationship between students and house officers and organized medicine was in its infancy. The groups were more like adversaries than associates. The relationship now is similar to that of a senior colleague to a junior colleague. Both students and house officers hold "business sessions" at which resolutions are debated so they may be introduced to the entire AMA House of Delegates for action. Both groups have one full voting delegate now and over half the state medical societies sponsored students to attend this meeting. I had to laugh when one resident expressed shock when told that contrary to his belief, students and residents had not always been involved in organized medicine. The cordial, almost paternal feeling the AMA has for students and house officers, can be understood when one examines present membership statistics. I felt at this meeting, that some influential AMA members have finally realized that the future of the AMA lies in recruiting membership among young physicians. In 1979 the AMA had 192,200 dues paying members. However, 40,550 of those were medical students and house officers, who pay $15.00 and $35.00 respectively. Active members paying full $250.00 per year dues, numbered 151,041, or about 47% of the active physicians in the United States. Even with the reduced dues, only one third of all medical students and house officers are AMA members.

Next, when one considers that the AMA's primary problem is membership, it is surprising to me that less than 5 pages in the 3″ thick delegate's handbook, dealt with this subject. There are some new plans to increase membership yet none seem to hit the primary reason that AMA membership is falling. I have heard it said time and time again, that non-members don't join because they think the AMA is doing nothing for them, and therefore, they get the best of both worlds. They save the $250.00 per year in dues and reap benefits from AMA actions which benefit all physicians, not just AMA members. As one delegate told me, "Half the physicians in this country are paying dues to give a free ride to the other half." Unfortunately, no one has been able to formulate a solution to this complex problem.

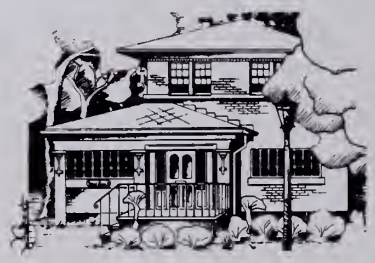
In addition, I am equally as impressed now with how democratic the federation concept of organized medicine

actually is, as I was eight years ago. While I may not agree with every AMA policy, I am still a member and know that a mechanism for change exists within the organization. I have had the opportunity to participate in the policy making process and know that it works. Perhaps if more physicians understood the mechanics of decision making in organized medicine, more physicians would become involved.

Finally, Florida physicians can be proud of the dedication our state delegation has for its job. Florida has seven delegates and seven alternates. They serve without pay and attend at least two five-day sessions per year, plus the FMA annual meeting. They must wade through a delegate's handbook, which by actual measurement was 3" thick. Numerous Board of Trustee reports must be read and over 100 resolutions acted upon. The time needed to prepare oneself for these meetings, is measured in weeks instead of days. Delegation caucuses, in wh. .h decisions are made concerning support on various issues, start every morning at 7:00 a.m. I speak from first hand observation when I say that the FMA Delegation has the interest of Florida's physicians at heart.

I would urge anyone with an interest in the politics of organized medicine to attend a meeting of either the Florida Medical Association, or the American Medical Association. It is a unique experience, which can be both exciting and educational. Attending the recent AMA meeting was like a homecoming. I was able to renew many acquaintances and establish countless new ones. As I left the meeting, I firmly resolved that I would not wait eight years to attend another.

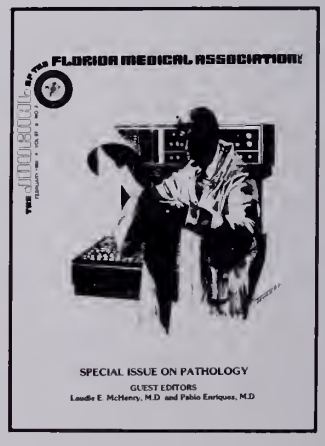
Lee A. Fischer, M.D.
Assistant Editor
West Palm Beach



Journal Pathology Issue Recognized

The Journal of the Florida Medical Association has been recognized by the Florida Magazine Association in its 25th annual competition. The magazine was awarded a certificate of merit for its writing in the best special issue category for the Special Issue on Pathology (February 1980). Guest Editors for the issue were Laudie E. McHenry, M.D., and Pablo Enriquez, M.D., both of Melbourne.

Journal Executive Editor Edward D. Hagan, immediate past president of the Magazine Association, accepted the award for FMA.



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Vitamin B_6	76	51	34
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Milk. Sometimes we forget all the good things it does.



Dean's Page

University of South Florida College of Medicine Status Report

Andor Szentivanyi, M.D.

The academic year of 1979-80 has seen the completion of several significant projects and fruition of various planning areas for the University of South Florida College of Medicine.

Of these, a total restructuring of the undergraduate medical curriculum that began almost two years ago should be noted. This effort, which has come to a culmination in this calendar year, has been marked by two events. First, the content and distribution of a new four-year curriculum, to replace the three-year model which had been employed, has been finalized and received faculty approval. Second, the first class admitted to the four-year curriculum arrived in September of 1980.

The process of spreading the curriculum over an additional academic year offered the opportunity both for addition of new material and for revision of established relationships. New curricular segments will be devoted to behavioral science, cross sectional anatomy and public health. Revision of the previous format will provide new identity for human genetics, oncology, nutrition, and geriatrics. Also, expanded clinical opportunities will involve neurology, ophthalmology and ambulatory care. While the major thrust of the change occurs with the introduction of the new curriculum, a mechanism for continuing evolution of curricular structure has been established.

Our College of Medicine graduated 96 physicians in June, 1980. These graduates accepted first year residency positions in 14 different specialties. Fifty-two percent selected the areas of family medicine, obstetrics and gynecology, internal medicine, and pediatrics. Sixteen percent selected surgery and its subspecialties, seven percent will enter programs in pathology and four percent chose programs in psychiatry. There is a good geographic distribution among the programs accepting our graduates. Twenty-seven states and Canada are represented among these programs. Twenty-two graduates entered the University of South Florida College of Medicine Affiliated Hospital programs.

There are some figures of interest to the citizens of the State of Florida on the 1980-81 first year class of 96 students. There are 32 undergraduate schools represented in the class. Fifty-six of the students received their premedical education at one of the schools in the State University System, and there are 28 females in the class. Of the 67 counties in the state, 28 are represented in the class. Thirty-seven of the students were born in Florida; 77 received all of their high school education in Florida with an additional six receiving part of their high school education in the state.

Two important centers were established during this academic year: the Diabetes Center, funded by the State, and the Suncoast Gerontology Center for Health and Long Term Care, both of which are examples of interaction between the faculty of the College of Medicine, the lay community, as well as the State and Federal agencies. Likewise, the planning process for the development of a Comprehensive Cancer Treatment and Research Center is underway.

The University of South Florida Medical Clinics saw the completion of some ambulatory surgical facilities which have increasing use and educational value as well. The College of Medicine was granted full membership in the Southeastern Oncology Group for cancer treatment.

In December of 1979, the Director of the USF Medical Center and the Dean of the College of Medicine, Dr. Hollis Boren, resigned, and Dr. Andor Szentivanyi was appointed as Interim Dean and Director. Three new

Dr. Szentivanyi is Interim Director of the Medical Center, and Interim Dean of the College of Medicine, University of South Florida.

positions have been added to the administration of the College: Associate Dean for Research and Graduate Affairs, Associate Dean for Continuing Medical Education and Associate Dean for the Medical Clinics. These positions were filled with the appointments of Drs. Carleton Baker, Frank Cozetto, and William Rush, respectively. Two new chairpersons were also appointed this year, Dr. William Layden for Ophthalmology, and Dr. Johannes Rhodin for Anatomy.

The faculty continues to increase significantly its research grants, publications, awards, and honors, and is looking confidently toward the developments of the coming decade.

- Dr. Szentivanyi, University of South Florida, Box 1, 12901 North 30th Street, Tampa 33612.

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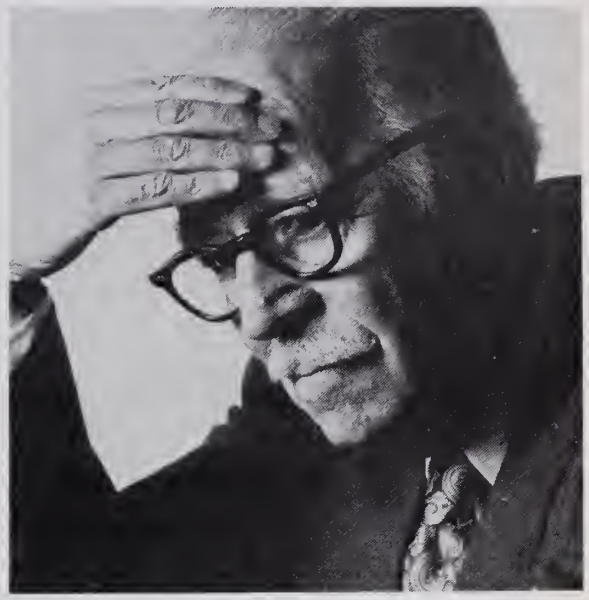
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ADVERSE REACTIONS: Cutaneous vasodilation with flushing. Headache may commonly occur, and may be both severe and persistent. Transient dizziness and weakness, in addition to other signs of cerebral ischemia associated with postural hypotension may occasionally be seen. ISO-BID can act as a physiological antagonist to norepinephrine, histamine, acetylcholine and many other medications. An occasional patient may show marked sensitivity to the hypotensive effects of nitrite; severe responses (nausea, vomiting, weakness, restlessness, pallor, excessive sweating and collapse) can occur, even with the usual therapeutic dosage; alcohol may enhance this effect. A drug rash and/or exfoliative dermatitis is occasionally seen.

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Diagnosis and Management of Acute Leukemia in Children

Paulette Mehta, M.D.

Leukemia is the most common form of cancer in children, and in the United States cancer causes more deaths among children than any other disease. Prognosis in childhood leukemia has improved dramatically in the past decade with early diagnosis and new therapeutic interventions contributing significantly. As an increasing number of patients survive, several long-term problems are being identified from alterations in the natural history of leukemia and pharmacotherapy.

The role of the practicing physician has become more important in early diagnosis, treatment in conjunction with the hematologist-oncologist, and recognition of early and late complications arising from long-term therapy. This discussion reviews common aspects of childhood leukemia as related to the general physician.

Types of Leukemia

Most children with leukemia have the acute form of disease; lymphocytic and myelocytic are most common. Acute lymphocytic leukemia accounts for 80% of leukemias and acute myelocytic 15%. Other acute leukemias include monocytic, myelomonocytic, promyelocytic, histiocytic, eosinophilic, erythroleukemia, and blast crisis of chronic myelogenous leukemia.[1,2]

The type of leukemia can usually be ascertained by examination of bone marrow morphology and by special cytochemical stains.[1,5]

Characteristics of lymphocytic leukemias include blast cells containing unclumped chromatin, high nucleus/cytoplasm ratio and nongranular cytoplasm (Fig. 1). In contrast, myelocytic cells (Fig. 2) have lower

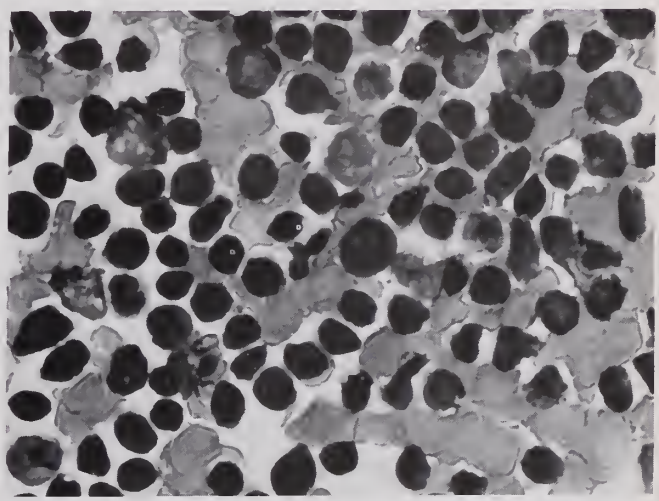


Fig. 1. — Bone marrow aspirate with almost total replacement of cells by lymphoblasts.

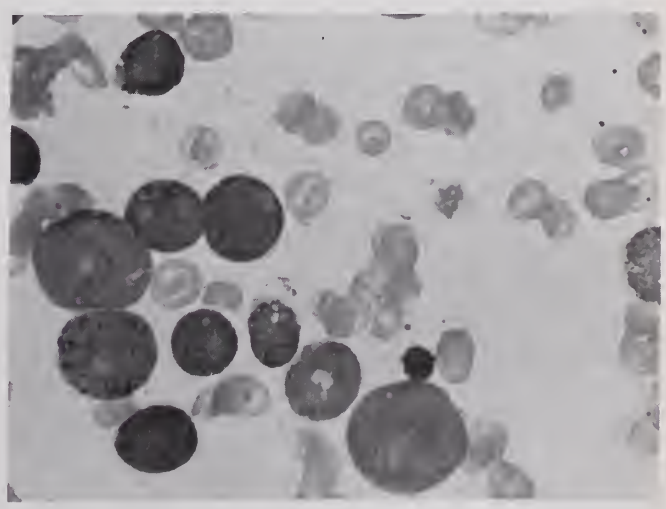


Fig. 2. — Bone marrow aspirate containing myeloblasts with obvious nucleoli and cytoplasmic granules.

The Author

PAULETTE MEHTA, M.D.

Dr. Mehta is Acting Chief, Division of Pediatric Hematology/Oncology, University of Florida College of Medicine, Gainesville.

Table 1. — Stains for Identification of Common Acute Leukemias.

Type of Leukemia	Stain
Acute Lymphocytic	
Null Cell	Periodic Acid Schiff
T-Cell	Acid Phosphatase
B-Cell	Periodic Acid Schiff
Acute Myelocytic	Sudan Black, Peroxidase, Acid Phosphatase, Chloroacetate
Acute Monocytic	Sudan Black, Peroxidase, Acid Phosphatase, Esterase (non-specific)
Acute Myelomonocytic	Sudan Black, Peroxidase, Acid Phosphatase, Esterase (non-specific), Chloroacetate.

nucleus/cytoplasm ratio, granules in the cytoplasm, and may contain Auer rods which, if present, are diagnostic. Special cytochemical stains may be necessary to distinguish the various types of leukemia (Table 1).

Lymphocytic leukemias can be subdivided into null cell, T-cell or B-cell types.[5-9] Lymphoblasts may bind to sheep red blood cells spontaneously (T-cell), contain surface immunoglobulins (B-cell) or do neither (null cell). Most (80%) lymphocytic leukemias are null cell type which are most responsive to therapy. T-cell leukemias represent approximately 16%, whereas those of B-cell type represent approximately 4% of all acute lymphocytic leukemias. Neonatal or congenital leukemia may be apparent at birth or may develop several weeks later; however, these are rare. In this age group, acute myelocytic leukemia is more common than acute lymphocytic leukemia compared with the older age group children. In either case, the prognosis is poor in neonatal leukemia.

Etiology

It has been proposed that leukemia may be caused by some viral agent because of reports of concentration of cases in certain communities and/or families, although no vertical or horizontal transmission has been demonstrated. Furthermore, viral agents have been identified in leukemia in certain species of mice and cats; however no virus or viral particles have yet been demonstrated in human leukemias. Association of irradiation, benzene derived chemicals and certain drugs such as chloramphenicol with leukemia have been observed. Genetic disorders such as Down's syndrome, Bloom's syndrome, congenital immunodeficiency states and Fanconi anemia are also associated with increased incidence of leukemia.

Incidence

Approximately one case per 25,000 persons under 25 years of age are detected in the United States. Peak incidence of acute lymphoblastic leukemia occurs at two to six years of age. Boys are afflicted more frequently than girls. Caucasians are more often affected than non-Caucasians. In acute myelocytic leukemia there is no predilection for age, sex or race.

Clinical Manifestations

The initial presentation of acute leukemia is extremely variable.[1,2] Manifestations of disease result from lack of a sufficient number of normal blood cells. Decrease in red blood cells results in pallor, fatigue, headaches, and other symptoms and signs. Decrease in platelets may cause ecchymoses end petechiae which may be mild and ignored by the patient. Acute bleeding may result in hematuria, epistaxis and hematemesis or a fatal central nervous system hemorrhage. Infections due to Pseudomonas aeruginosa, Escherichia coli and Staphylococcus aureus resulting in sepsis and pneumonia most often are common and serious offenders.

Crowding of the marrow with leukemic cells may result in bone pain, an initial presenting sign in approximately 10% of children. Leukemic involvement of abdominal organs results in distension and hepatosplenomegaly. Lymph nodes are usually mildly enlarged. Central nervous system involvement may cause cranial nerve palsies, intracranial hypertension or paralysis. Other manifestations include retinal hemorrhage, glaucoma, and infiltration of gingiva, tonsils, and appendix.

Laboratory Findings

Initial blood cell counts vary considerably. The total white blood cell count ranges from less than 1,000 to over 1 million with median of 13,000/mm^3. However granulocyte count is usually severely decreased. Platelet count also is usually markedly decreased. The hemoglobin values range from 2-15 gm% with average of 7 gm%.

Examination of the bone marrow is essential for diagnosis.

The cerebrospinal fluid contains leukemic cells in about 2% of patients with acute lymphocytic leukemia and in about 10% of patients with acute myelocytic leukemia. Examination of cells should be by cytocentri-

fuge. Roentgenologic examination of chest, bones and kidneys is helpful in the initial evaluation of patients. Chest x-rays may reveal enlarged mediastinum due to infiltration of thymus or perihilar lymph nodes involvement. Both findings indicate poor prognosis. X-rays of long bones may reveal transverse radiographic bands in metaphyses, periosteal evaluation, rarefaction and osteolytic lesions. Intravenous pyelogram is usually performed to evaluate kidney size and function.

Management of Leukemia

A. General Management

The objective of initial management of children suspected to have leukemia is to confirm its presence, begin specific chemotherapy and prevent complications. The family should be informed as to diagnosis and prognosis. The disease process should be explained to the family and the patient with concern and honesty.

Extent of leukemic involvement should be estimated by careful physical examination and other tests discussed earlier. Lumbar puncture is done to determine if central nervous system involvement is present. Liver, renal and cardiopulmonary functions are evaluated for possible involvement and compromise.

Generous fluid intake is encouraged to prevent precipitation of uric acid from breakdown of leukemic cells in the renal tubules. Allopurinol should be administered in addition. Transfusions of packed red blood cells are usually necessary to correct the anemia. Platelets should be given if the patient is thrombocytopenic and has bleeding problems. Infection should be treated early and aggressively with broad spectrum antibiotics.[10] Granulocyte infusions can be considered if fever and sepsis persist; these are more effective when given early and when blood cultures are positive.[11]

B. Drug Therapy

Drug treatment consists of several phases. **Induction phase** is the period from diagnosis to the time at which there is no detectable leukemic infiltration in blood, bone marrow or cerebrospinal fluid. If no further treatment is given after remission is induced, relapse occurs within four to six months because some leukemic cells persist. Thus additional therapy is necessary. **Consolidation phase** is the one to two week period after remission when intensive chemotherapy is given to achieve a rapid additional reduction in the leukemic cell population. **Maintenance phase** is the period when drugs are administered to keep the patient in remission.

Multiple drugs and drug combinations are employed. Since definitive therapy is not established, most medical centers use these drugs in protocol fashion. The pharmacotherapy mentioned in the following paragraphs is therefore only a general guideline and reflects the current protocols used in the teaching hospital of the University of Florida College of Medicine.

Acute Lymphocytic Leukemia

Patients with acute lymphocytic leukemia of null cell origin are randomized to one of two treatment groups. One group receives vincristine, prednisone and L-asparaginase during induction. After remission these patients receive methotrexate and 6-mercaptopurine daily for maintenance. Central nervous system prophylaxis consisting of intrathecal methotrexate and radiation is started along with maintenance therapy.

The other group of patients receive vincristine and prednisone during induction and later L-asparaginase and cycylophosphamide for consolidation. Following remission, intrathecal medications (methotrexate, hydrocortisone and cytosine arabinoside) are given in conjunction with intravenous methotrexate every other week for six weeks. Maintenance therapy consists of 6-mercaptopurine and methotrexate. In both groups, periodic administration of vincristine and prednisone are added to maintenance programs.

Patients with relatively good prognosis are given the first treatment protocol. Those with poorer prognosis receive the first or second protocol.

If patients relapse, they are induced again with vincristine and prednisone. Those who respond to vincristine and prednisone are maintained with vincristine, Adriamycin, prednisone and 6-thioguanine. Patients who do not respond are given L-asparaginase with or without Adriamycin.

New protocols are being developed regularly to improve results. One regimen presently being investigated at the University of Florida for the Southwest Oncology Group is for patients with poor prognosis null cell leukemia. Induction is attempted with cyclophosphamide, vincristine and prednisone. If induction is achieved, consolidation consists of L-asparaginase and cyclophosphamide. Maintenance therapy then incorporates 6-mercaptopurine and methotrexate with alternating short courses of drug combinations. These combinations include (1) vincristine, Adriamycin and prednisone; (2) cytosine arabinoside and prednisone, and (3) 6-thioguanine, cyclophosphamide and prednisone. These three combinations are given on a rotating schedule throughout three years of maintenance therapy.

Patients with T-cell leukemia are treated more aggressively with vincristine, prednisone, cyclophosphamide and daunomycin for induction. Radiation to primary area of involvement, if any, is given as well. Consolidation treatment includes cytosine arabinoside, L-asparaginase, 6-thioguanine and 1,3-bis(2-chloroethyl)-

1-nitrosourea. Maintenance therapy consists of cycles of eight different drugs: 6-thioguanine, cyclophosphamide, hydroxyureau, daunomycin, methotrexate, 1,3-bis(2-chloroethyl)-1- nitrosourea, cytosine arabinoside and vincristine.

Patients with B-cell leukemia receive induction therapy consisting of vincristine, cyclophosphamide, and high dose methotrexate for six weeks. After remission is attained, it is maintained by cycles of cyclophosphamide and vincristine with high dose methotrexate.

Acute Myelogenous Leukemia

Induction is attempted with vincristine, prednisone and Adriamycin. If patients attain remission, maintenance therapy consists of one of two drug combinations. One consists of cycles of 6-thioguanine and cytosine arabinoside alternating with cycles of cyclophosphamide, vincristine, prednisone and cytosine arabinoside. The other combination consists of these drugs as well as intermittent cycles of vincristine, Adriamycin and prednisone. Intrathecal medications and central nervous system radiation is given to all patients.

Central Nervous System Prophylaxis

Prior to routine prophylaxis, leukemic infiltration in the central nervous system is observed in more than one half the patients with acute leukemia. Conventional chemotherapy does not cross the blood brain barrier to eliminate tumor cells in the meninges. It has been shown that cranial irradiation (2400 rads) with intrathecal methotrexate can reduce the incidence of central nervous system leukemia to approximately 10%. This treatment has its own complications such as hair loss, nausea, vomiting, pain and headache. A self-limited period of somnolence and lassitude may occur several weeks after irradiation has been given. Leukoencephalopathy is a rare occurrence when irradiation and methotrexate are used concurrently.

C. Bone Marrow Transplantation

Recently bone marrow transplantation has become a therapeutic endeavor for acute leukemia, especially in cases resistant to conventional chemotherapy.[12] If a potential donor is available with identical HLA type and without reactivity of lymphocytes in mixed lymphocyte culture, bone marrow transplantation can be considered. Considering the poor prognosis in patients with acute myelocytic leukemia, several investigators have suggested use of bone marrow transplantation during the first remission. Major complications include graft versus host disease and infection.

Relapse

Relapse signifies the reappearance of leukemic cells at any site in the body. Central nervous system relapse still occurs in some patients. Testicular involvement may manifest itself as painless swelling. Irradiation usually is sufficient to eliminate the testicular tumors. However, systemic reinduction is necessary.

Early Complications

Children with leukemia are at risk of infection.[10] When patients are granulocytopenic they are especially susceptible to bacterial infections due to pseudomonas, klebsiella and E. coli. During remission most infections are nonbacterial. Pneumocystis carinii is not uncommon. Early diagnosis of this entity is important since mortality is very high in untreated or inappropriately treated patients.

Table 2. — Side Effects of Drugs Used in Treatment of Acute Leukemia.

Prednisone	Obesity, Hypertension, Monilia, Urinary Frequency, Hyperuricemia, Diabetes Mellitus
Vincristine	Paresthesia, Muscle Weakness, Loss of Deep Tendon Reflexes, Slapping Gait, Alopecia, Jaw Pain, Hyponatremia
Methotrexate	Mouth Ulcers, Bone Marrow Suppression, Hepatitic Necrosis, Pulmonary Infiltrates
6-mercaptopurine	Bone Marrow Suppression, Hepatitic Necrosis
Cyclophosphamide	Bone Marrow Suppression, Hemorrhagic Cystitis, Immunosuppression
Cytosine Arabinoside	Mouth Ulcers, Bone Marrow Suppression, Alopecia
Adriamycin and Daunomycin	Bone Marrow Suppression, Alopecia, Ulceration if Extravasation Occurs, Cardiotoxicity
L-asparaginase	Liver Function Abnormalities, Hypersensitivity Reactions, Disseminated Intravascular Coagulation, Depression of Coagulation Factors, Pancreatitis

Varicella is a constant threat to patients. Parents and teachers should be warned against contact of child with an individual with varicella lesions. If contact is determined early within 48 hours, immune globulin may be of help in circumventing the disease.

Metabolic complications can occur early in the course of disease. The increased uric acid load from leukemic cell breakdown can lead to nephropathy with renal failure and gouty arthritis. Hypercalcemia, due to production of a parathormone-like substance liberated by leukemic cells, or hypocalcemia in response to high phosphate from lymphoblast breakdown is also seen. Other metabolic abnormalities such as hypoglycemia and chronic lactic acidosis may also be observed. Other complications are listed in Table 2.

Long Term

With increasing survival, many long-term complications of disease and treatment are being observed (Table 3). It is important for the practicing physician to be aware of potential problems so that these can be accurately identified and treated, if possible.

Table 3. — Some Long-Term Complications of Chemotherapy.

Drug	Complication
Adriamycin and Daunomycin	Cardiomyopathy, Congestive Heart Failure
Methotrexate	Hepatic Fibrosis and Cirrhosis, Teratogenesis, Leukoencephalopathy (if Associated with Cranial Irradiation), Secondary Tumors
6-mercaptopurine	Hepatitic Fibrsis and Cirrhosis, Teratogenesis, Secondary Tumors
Cyclophosphamide	Sterility, Secondary Tumors
Steroids	Growth Retardation

Cessation of Therapy

The dangers of chemotherapy such as drug toxicity, irreversible bone marrow damage, hepatotoxicity, immunosuppression, growth retardation and development of secondary tumors become more pronounced as the period of treatment is extended. Chemotherapy is therefore usually stopped between two and five years after initiation.[13] A long term follow-up of these patients is not available at this time.

Prognosis

Prognosis for prolonged survival has increased in recent years. In acute lymphocytic leukemia, approximately 50% of children survive five years or more. Patients with acute myelocytic leukemia have only a 20% survival at two years. Certain features in acute lymphocytic leukemia are useful in predicting prognosis. Age between two and six years, low white blood cell count, limited organ involvement, lack of T or B-cell markers and lack of mediastinal mass favor a good prognosis.

Patient, Family and Physician Relationship

The diagnosis of leukemia is a catastrophe and the entire family may require extensive support from the health care team. Siblings of the patient may suffer from the knowledge of "cancer" in the family and wonder how such a thing could happen. They often show remorse over diversion of all attention to the sick child. The child may be intensely apprehensive and frightful the pain, procedures, treatment and hospital environment in which he/she is suddenly thrust. He/she usually understands that something is very wrong and needs a compassionate, honest answer appropriate to his level of understanding and age. The teenage child may have immense anxieties about relations with peers, his future and of dying. The physician needs to establish an intimate but honest relationship in order to win the cooperation of the child during treatment.

Summary

Since childhood leukemia is a common disease, the physician can expect to see several of these patients in his practice. Referral to a major medical center for diagnosis and management is important. The hematologist-oncologist and the physician later share in joint management. Treatment involves several chemotherapeutic agents designed to induce remission systemically as well as prophylactic treatment of sanctuary areas such as the central nervous system. Prognosis has improved dramatically recently, especially in lymphocytic leukemia. As patients survive for longer periods of time, several late complications may be anticipated.

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Intranasal Leiomyosarcoma

George L. Kullman, M.D.

Leiomyosarcoma of the nasal passages is a rare disease first reported by Dobben[1] in 1958. Dropkin[2] summarized the literature in 1976 reporting a total of 14 cases to which he added one of his own. Kakar,[3] in addition, reported two cases in 1978. This report brings the total number of cases to 18.

Case Report

The 66-year old Caucasian male, referred by his cardiologist for epistaxis, was being treated for angina pectoris, chronic obstructive pulmonary disease and gout. The patient experienced, in addition, unilateral nasal obstruction, but no pain.

Examination revealed a nonulcerated, pink tumor which filled the entire left nasal cavity. The tumor bled on manipulation, was visible in the posterior choana, but did not extend into the nasopharynx. Sinus x-rays showed filling of the left nasal passage, with mucous membrane hypertrophy of the antrum (Fig. 1). The remaining findings including neck examination and chest x-ray were normal. Preoperative biopsy revealed leiomyosarcoma.

During a lateral rhinotomy surgical approach, the tumor was found to arise in or near the nasoantral wall and had completely replaced the inferior turbinate. It had apparently become secondarily attached to the nasal septum. The surgery included total removal of the middle turbinate, anterior ethmoid cells and the entire medial wall of the antrum. A large portion of the nasal septal mucosa and underlying cartilage at the site of attachment was also removed. The mucous membrane of the opposite side of the nasal septum was left undisturbed.

In view of the known poor prognosis of this tumor, postoperative consultation with the radiotherapist and oncologist culminated in the adjuvant treatment with actinomycin-D 0.015 mg per Kg intravenously for six days every four weeks over a period of six months.

There has been no sign of recurrence or metastasis for three years.

Pathology

Leiomyosarcoma is a malignant tumor of smooth muscle origin. It is assumed that in the head and neck area the origin lies in the smooth muscles of the blood vessel walls.

On gross examination, this tumor was found to be smooth, firm, with no distinct capsule. The pathologist described it as being whitish tan in appearance, gritty, with a homogeneous whitish gray cut surface.

On microscopic examination, with H & E staining, the tumor showed a composition of spindle-shape cells with plumb nuclei with round ends and fine intracytoplasmic fibrils which extended for long distances on both sides of the cytoplasm (Fig. 2).

The tumor cells arranged in bundles often presented a herring-bone pattern. Mitoses were frequently seen, some were bizarre. Nuclear pleomorphism was noted in some areas with bizarre, lobulated or multinucleated cells, occasionally giant in shape. There was much hyalinization of the stroma in some areas resembling chondroid tissue.

Special stains demonstrated brilliant red intracytoplasmic fibrils with Masson's trichrome and sparse collagen, especially in the most cellular areas. Collagen was prominent deeper in the tumor, where extensive hyalinization had occurred.

Reticulum stains also revealed reticulin fibers running in parallel fashion surrounding the tumor cells.

The areas where nasal epithelium was seen showed foci of squamous metaplasia without apparent dysplasia. There were also areas where ciliated epithelium was observed. There was no bone metaplasia.



Fig. 1 — Sinus x-rays showing filling of left nasal passage, preoperative.

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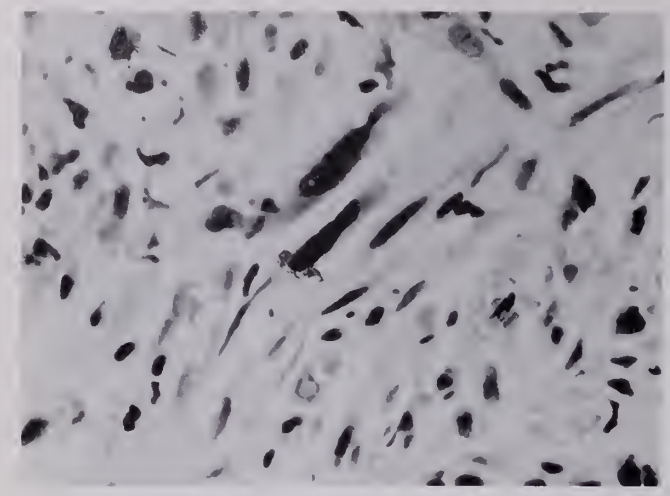


Fig. 2 — Pathologic appearance of tumor (H.+E. ×250).

Electron microscopy showed the tumor cells to contain myofibrils, pinocytotic vesicles and desmosomes. Basement membrane material was seen around many cells. These features are consistent with smooth muscle.

Discussion

Presenting signs and symptoms

Of the previously reported 17 cases, nasal obstruction was the primary complaint in 13, epistaxis in seven, facial pain in five, facial swelling in three and rhinorrhea in one. The average patient age was between 60 and 70 with a range from 18 to 75 years. There appears to be no predominant involvement either by sex or race.

Treatment

Radical surgical excision is apparently the most successful form of initial treatment. The number of reported cases, however, are too few to offer statistically significant figures for prognosis, regardless of therapy used. Pimpinella and Marquit[4] stated in 1965 that the tumor is quite radio-resistant and Mindell[5] points out its generally poor prognosis. In view of these findings, our patient was treated with both surgery and chemotherapy.

In approximately 75% of the cases reported there was local recurrence. Of these, the mortality rate was 50% within a period of one to three and one-half years. In regional neck metastases, radical neck surgery is apparently the only effective therapy.[5] In distant metastases, however, there is virtually no survival.

There is evidence that leiomyosarcoma in this area carries a high recurrence rate and, according to Mindell,[5] such recurrence may manifest itself from four to six years after initial treatment. Long-term follow-up, therefore, is of primary importance to the welfare of these patients.

Overall survival

All the long-term survivors were initially treated by wide surgical excision. Although recurrent tumor will result in an approximate 50% mortality, still the surgical procedure demonstrates the most effective modality of treatment. In both primary and recurrent leiomyosarcoma of the head and neck region, it is apparent that this procedure provides the optimum therapeutic benefit.

Radical neck dissection is reserved for manifest metastatic lymph node involvement.

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Fifty Years Ago

In *The Journal of the Florida Medical Association* for October 1930:

Paul T. Butler, M.D., of Orlando, published an article on "Venomous Snakes" . . . Seventy doctors registered for the fourth meeting of the Florida East Coast Medical Association in Melbourne, October 2-3. According to *The Journal's* account: "**Dr. Calvin D. Christ,** of Orlando, appeared to be having a very delightful time, especially out at the Country Club at the dance. Several of the ladies said he was as light on his feet as if he weighed one hundred pounds, and was twenty years of age." . . . On a trip north, **L. M. Anderson, M.D.,** of Lake City, stopped off in Washington to appeal for the location of a National Soldiers' Home in Florida . . . FMA President **J. C. Davis, M.D.,** of Quincy, returned from a vacation in the North Carolina mountains . . . Southern Medical Association advertised membership at dues of $4.00 a year which included a subscription to *The Southern Medical Journal,* which was described as "the equal of any, better than many" . . .

And so it was in Florida medicine 50 years ago this month. — E.D.H.

Hypocalcemia and Hypovitaminosis D in an Infant from Florida, the Sunshine State

Allen W. Root, M.D., Alfonso Vargas, M.D., Gregory E. Duckett, B.S. and Gerard Hough, M.D.

Cholecalciferol (vitamin D_3) is generated in skin by the ultraviolet irradiation of its precursor 7-dehydrocholesterol.[1] After transport to the liver vitamin D_3 is hydroxylated to produce 25 hydroxycholecalciferol ($250HD_3$).[1] $250HD_3$ is the major circulating metabolite of vitamin D accounting for more than 85% of serum 250HD even in northern climes.[2] The serum concentrations of 250HD are significantly higher in Florida children than in Pennsylvania children,[3] presumably due to greater exposure to sunlight. Many studies have documented the augmenting effect of intensive exposure to sunlight upon serum 250HD values.[4,5]

The most common causes of hypocalcemia in children past the neonatal period are hypoparathyroidism, pseudohypoparathyroidism (end organ insensitivity to parathyroid hormone (PTH)), hypomagnesemia, hypovitaminosis D, hypernatremia, hypokalemia and sepsis.[6] Lack of vitamin D might be considered an unusual cause of hypocalcemia in Florida children. We report a 13-month boy with hypovitaminosis D and hypocalcemia. The observation indicates the importance of determining the serum concentrations of both PTH and 250HD in patients with hypocalcemia even in Florida.

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Report of Case

A 13-month-old black male presented with a three week history of lethargy and muscular stiffness, twice requiring hospitalization. When the third episode of stiffness occurred the child was admitted to Tampa General Hospital. Physical examination disclosed an irritable, diaphoretic youngster with extreme hypertonicity of the muscles of the extremities, neck and abdomen. During examination the infant had a tonic grand mal seizure. His height age was equal to chronologic age. There were no physical stigmata of rickets.

Past medical history revealed that the infant had been well until four months of age when bronchospastic respiratory distress developed which required several hospitalizations in rapid succession. The question of an allergic diathesis was raised. All milk products were withdrawn and the child was presented a diet of meat, vegetables, grits, cereal, tea and gelatin water. It was estimated that the diet provided approximately 90 mg of elemental calcium per day. Vitamins were administered sporadically at best. Because of respiratory illnesses, the boy was maintained inside except for trips to the doctors or hospital.

Radiographic Studies. — Serial skeletal surveys over several months revealed no abnormalities suggestive of rickets, although initially there may have been slight demineralization of the phalanges of the hand. Bone age was compatible with chronologic age.

Laboratory Methods. — Serum concentrations of 250HD and immunoreactive parathyroid hormone (iPTH) were determined by competitive radioassays previously reported.[7,8] Serum levels of calcium, phosphorus, alkaline phosphatase, electrolytes and other serum constituents were measured in the chemistry laboratories of the Tampa General and All Children's Hospitals.

Initally the serum calcium concentration was 5.1 mg/dl. Prior to administration of calcium the serum concentration of iPTH was 840 pg/ml (normal <200) while the concentration of 250HD was <1.0 ng/ml (normal range 15-40 ng/ml). The phosphorus concentration was 6.4 mg/dl, while the alkaline phosphatase activity was 621 IU/L (normal for age <400). Urinalysis, serum electrolytes, BUN, creatinine and screening chemical studies were normal. Cultures of blood and cerebrospinal fluid were sterile.

The infant responded to intravenous calcium (2 mg/kg) with cessation of the seizure and decrease in muscular hypertonicity. After a postictal period of eight hours, the neurological and developmental examinations were normal for age. The serum calcium concentration returned to normal upon supplementation of his diet with 500 mg of elemental calcium (as calcium lactate), and liberalization of the diet to include vitamin D fortified milk and related products (Fig. 1). Upon discharge the mother was encouraged to permit her child to play outdoors.

Without supplemental vitamin D the serum concentration of 250HD increased to 12 ng/ml within one month and to 26 ng/ml within ten months, while the elevated iPTH level declined to the normal range within two months after the acute illness. Ten months after the acute illness, calcium lactate was discontinued, and a multivitamin preparation containing 400 units of vitamin D^3 initiated. The child has remained well.

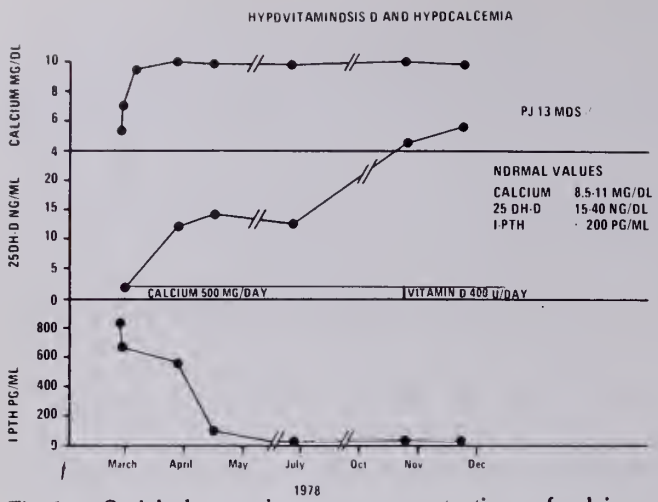


Fig. 1. — Serial changes in serum concentrations of calcium, 250HD and iPTH.

Discussion

The data suggest that the hypocalcemia in this patient was the result of deficiency of both dietary calcium and of exogenous and endogenous vitamin D. The rapid normalization of serum calcium concentrations with intravenous and oral calcium, spontaneous increase in serum vitamin D level with liberalization of diet and increased sunlight exposure, decline to normal of elevated concentrations of iPTH, and normal studies of renal function suggest that there was no intrinsic abnormality of vitamin D metabolism, congenital end organ insensitivity to PTH, or impairment of renal function in this patient. Although magnesium concentrations were not measured, the patient's course suggests that it is unlikely a deficiency was present. Magnesium is necessary for secretion of PTH, and serum levels of iPTH are low in magnesium-deficient subjects.[9]

The serum concentration of iPTH which remained increased for more than one month, despite return to normocalcemia, suggests that the abnormal state of calcium homeostasis in this child may have been of relatively long duration. Since the secretion of PTH is finely regulated by ionized calcium values,[1] one might hypothesize that there was a degree of parathyroid hyperplasia which had to regress prior to normalization of iPTH levels. Increased concentrations of iPTH are well recognized in nutritional rickets.[10]

The absence of clinical or radiographic signs of rickets and normal linear growth may be analogous to the experimental situation characterized by Harrison et al.[6,11,12] They noted that rickets occurred only in vitamin D depleted rats ingesting high calcium, low phosphorus diets. These animals had normal serum calcium levels. In vitamin D deficient rats receiving normal amounts of dietary calcium and phosphorus, there was significant hypocalcemia, normal serum phosphorus levels and absence of histological signs of rickets in the bones. The combined effects of hypocalcemia and hypovitaminosis D (both necessary for the biological activity of the PTH) may have protected the skeleton of our patient from the calcium mobilizing effects of PTH, thereby preventing development of florid rickets. It is also possible that in our patient the duration of vitamin D deficiency was inadequate to produce obvious signs of rickets, although alkaline phosphatase activity was increased. Bone biopsy might have revealed characteristic microradiographic findings of vitamin D deficiency.[13] Recently Ediden et al[14] reported 10 Chicago infants with nutritional rickets due to unsupplemented breast feeding and/or a purely vegetarian diet. All these children were small with physical and roentgenographic findings of rickets and in two patients there was severe hypocalcemia (4.6, 5.1 mg/dl) and marked hypophosphatemia (1.9, 2.1 mg/dl, respectively). These children differed clinically and biochemically from our patient which may have reflected differences in calcium phosphate intake between the children. Such differences might also explain, in part, the normal phosphorus concentration in our patient.

This patient demonstrates that vitamin D deficiency may occur in otherwise healthy Florida residents and that measurement of serum concentrations of 250HD, the major metabolite of vitamin D, is a useful diagnostic tool in the evaluation of a patient with hypocalcemia.

Acknowledgement

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Toxic Shock Syndrome With Vaginal Ulceration

Mary E. Raum, M.D., Eduard G. Friedrich Jr., M.D. and James I. Slaff, M.D.

Abstract: The recent identification of Toxic Shock Syndrome was highlighted in the FDA Drug Bulletin July 1980. The disease is characterized by the sudden onset of fever ≥102°F, erythematous rash with subsequent desquamation, systolic blood pressure ≤90 mm Hg for an adult, involvement of at least four organ systems and reasonable evidence for absence of meningitis and bacteremia. Since the beginning of this year, over 100 cases have been reported to the Center for Disease Control from other states. The following case report describes one of the first cases of this syndrome to be recognized in the State of Florida.

Toxic Shock Syndrome (TSS) generally occurs in previously healthy young women of childbearing age and begins with high fever, vomiting and progressive hypotension. A sunburn-like rash with eventual desquamation of the skin of the palms and soles usually accompanies the disease. Non-purulent conjunctivitis is common and many other organ systems may be involved. Reported cases have shown renal function abnormalities, cardiac dysfunction, hematologic disorders, adult respiratory distress syndrome, and CNS involvement.

A team of investigators from the Center for Disease Control (CDC)[1] has linked the occurrence of the syndrome to the use of tampons, and coagulase-positive staphylococcus aureus was isolated from the vagina in most cases studied.

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Case Report:

The patient was a 16 year old black female from rural Florida, Para 0000 whose current menses began five days prior to admission. She was accustomed to using tampons for menstrual protection and inserting them blindly. She had used superabsorbent tampons continuously for the current menses (Playtex and one Rely), changing them three or four times per day. She awoke the morning of the fifth day of the period with a severe bifrontal and occipital headache. Shortly thereafter she noted burning of her eyes and experienced two episodes of vomiting. Her temperature taken at home was 103°F. She was admitted that evening to the Emergency Room at the Shands Teaching Hospital in Gainesville.

She denied neck pain or stiffness, pelvic discomfort, recent febrile illness, trauma, exposure to hepatitis, or illness among family members. She had no past history of a similar problem.

The admission blood pressure was 90/54 mm Hg, pulse 118, temperature 39.0°C (102.2°F). The conjunctiva were injected, and palmar erythema was present. Nuchal rigidity and lymphadenopathy were absent. The remainder of the physical examination was unremarkable except for the findings on pelvic examination. The vulva appeared to be normal. A tampon was present within the vaginal lumen and was removed. The tampon was saturated in one area with a purulent exudate which was cultured. The vaginal mucosa was erythematous and inflamed and a marked purulent exudate was present. Colposcopic examination of the vagina revealed a small ulcer on the portio vaginalis of the anterior cervical lip. Tampon fibers could be seen imbedded within the ulcerated area. A wet smear of the discharge showed only polymorphonuclear leucocytes. No trichomonads were seen. Cultures of the vulva, vagina, and cervix were taken. Bimanual examination demonstrated a palpably normal uterus and adnexae with an absence of pelvic tenderness or masses.

Admission laboratory values were reported as follows: WBC 21,400; differential — 78 polys, 15 bands, 5 lymphs, 1 mono; target cells

and Doehle bodies were present; Hgb 14.5, Hct. 43%, ESR = 27 (normal 0-20). An EKG and chest X-ray were normal. Routine blood chemistries and liver function tests were all normal except for an elevated BUN of 24. Lumbar puncture was performed with normal pressure and CSF profile.

The vagina was thoroughly cleansed with hydrogen peroxide, saline, and povidone-iodine solution. Intravenous fluids were started and antibiotic therapy with Nafcillin and Gentamycin was instituted. The patient was initially admitted to the intensive care unit and closely observed for progression of the disease with maintenance of hydration and nutrition. During the next 48 hours the temperature, blood pressure, and pulse returned to normal. Intravenous antibiotics were discontinued, and oral dicloxacillin was substituted. The conjunctiva initially became more injected and then began to clear. A generalized rash was not observed and desquamation of the palms did not occur. The BUN dropped from 24 to 5 and no oliguria was noted. The platelet count decreased to 198,000 on the first day of hospitalization then gradually rose to 235,000. The WBC gradually returned to 9,100 with a normal differential distribution. The patient did well with progressive diet and ambulation and was discharged on the third hospital day. Oral dicloxacillin was continued for an additional eight days, as beta-lactamase resistant penicillin therapy has been demonstrated to reduce the risk of recurrence. She was instructed to refrain from tampon use for the next six cycles.

Cultures of the tampon, vulvar labia majora, vagina, and cervix showed a heavy growth of coagulase positive, penicillin-resistant staph. aureus. Cultures of the CSF, blood, and urine were sterile while those of the nares and stool grew normal flora.

Three weeks after leaving the hospital she noted superficial desquamation of her palmar skin. When seen in follow-up after one month, she had experienced another menstrual period without difficulty. On repeat colposcopy the cervico-vaginal ulcer had completely healed. Repeat cultures of the vulva and the vagina showed no evidence of staphylocci.

Discussion

In 1978, Todd et al.[2] described a toxic shock syndrome in older children associated with phage group-1 staphylococci. They reported seven cases of an acute multisystem disease and remarked on the similarity of this new entity with other staphylococcal entero-toxin related diseases such as food poisoning. They suggested that a staph. exotoxin might be responsible.

Since then, a team of investigators at the CDC in Atlanta has collected over 200 cases of similar syndrome occurring during menses in women between the ages of 12-52.[3] Separate studies by the CDC, the Wisconsin State Department of Health and Social Service and the Utah State Department of Health showed a remarkably high association with the use of tampons. No differences were found in the brand of tampon used. Since of 70% of menstruating women in the United States use tampons, and since the incidence of TSS has been estimated at 3 per 100,000, tampon use itself is not sufficient to cause the disease. Instead, the tampon may act as a fomite for the introduction and subsequent growth of the toxin-producing organism.

Staph. aureus is rarely encountered in the normal cervix or vagina.[4] However, 67% of women in one study harbored the organism on the vulva.[5] Friedrich has suggested that tampons become contaminated from the vulva at the time of insertion and when subsequently saturated with menstrual exudate within the vaginal incubator, serve as a growth medium.[6]

How the exotoxin is absorbed is not known, but staph. organisms themselves require damaged epithelium before tissue invasion can occur. It is possible that localized breaks in the vaginal wall (ulcerations) may facilitate toxin absorption. Friedrich and Siegesmund noted that tampons produce alterations in the vaginal mucosa when the epithelium is viewed through a colposcope.[7] Super-absorbent-containing tampons are particularly likely to result in transient microulcerations. Whether or not such alterations play a role in the development of TSS has yet to be determined. The present case is the first known in which such ulcers have been sought and demonstrated.

Although this case lacked the characteristic sunburn rash, which may have been masked by the skin color, we feel that it clearly represents an example of the toxic shock syndrome. The abbreviated course, without progressive renal involvement and deepening hypotension, may be related to early recognition of the disease followed by prompt therapy. An immediate decrease in the inoculum of organisms and toxin was achieved by removal of the tampon and thorough vaginal cleansing. This case demonstrates the value of vulvar and tampon culture and vaginal colposcopy; such procedures should be added to the CDC recommendations of cervical-vaginal, blood, nares, urine and stool cultures.

Futher cases may be expected to occur in the State of Florida and should be reported to the State of Florida Department of Health and Rehabilitative Services, Jacksonville, Florida 32201, as well as to the Special Pathogens Branch, Bureau of Epidemiology, CDC, Atlanta, Georgia 30333.

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● Dr. Raum, Box J-294, JHMHC, Gainesville 32610.

SPECIAL ARTICLES

The Florida Board of Medical Examiners

Editor's Note: The following information was compiled by the State Board of Medical Examiners. Updated material is scheduled to be released on a quarterly basis.

The Florida Board of Medical Examiners (FBME) was created by legislative action to deal with medical licensing and competence in Florida. The Board consists of 11 members of whom nine are licensed physicians and two are lay members. All were appointed by Governor Graham for two, three, or four year terms and were subject to Senate confirmation.

The Board members and expiration dates of terms are:

James Carver Boyd, M.D.	Pensacola	1982
Ben M. Cole, M.D.	Orlando	1981
Richard T. Conard, M.D.	Bradenton	1982
Richard J. Feinstein, M.D.	Miami	1982
Alberto M. Hernandez, M.D.	Miami	1982
Robert B. Katims, M.D.	Miami	1983
John N. Sims, M.D.	Ft. Pierce	1983
Jeraldine Smith	Tallahassee	1981
Raul Valdes-Fauli	Miami	1983
Dana V. Wallace, M.D.	Hollywood	1981
Robert N. Webster, M.D.	Tallahassee	1981

The work of the FBME is governed by the Medical Practice Act of 1979, Chapter 458, Florida Statutes, which was rewritten in 1979 after undergoing the Sunset Review Process in Florida. Much of the autonomy which was previously held by the Board is now given to the newly restructured Department of Professional Regulation.

Medical Licensing in Florida

A valid Florida medical license may be obtained in various ways.

The Board may issue a license by endorsement to a graduate of an accredited medical school with one year AMA approved postgraduate training or five years licensed practice of medicine who has been certified as having passed either the (1) FLEX (Federation Licensing Examination) (2) or National Board examination within the previous 10 years.

The physician who recieves his license by endorsement is required by the Florida Medical Practice Act to commence practice in Florida within three years of the date of the issuance of the license and continue such practice for one year. Failure to fulfill this requirement will result in the license being declared "Null and Void." Sixty-two medical licenses granted by endorsement in April, 1977, were invalidated at the June, 1980, Board meeting due to the licensee's failure to meet this requirement.

A physician may also become licensed in Florida by taking and passing the Board's medical licensure examination. Florida now utilizes the FLEX examination as its licensing examination. The FLEX examination is now given by all 50 states and is offered twice a year — June and December.

Graduates of foreign medical schools who have completed one year postgraduate training in an AMA approved program, or five years licensed practice of medicine, and who have passed the Educational Commission Qualification Examination for Foreign Medical Graduates are eligible for licensure in Florida by examination or by endorsement if they have passed the FLEX examination in another state within the previous 10 years.

Graduates of American schools of osteopathic medicine are also eligible for licensure by the Florida Board of Medical Examiners if they have completed one year postgraduate medical education in an AMA approved program and have been certified by one of the appropriate American Specialty Boards accredited by the American Medical Association.

Medical Competency in Florida

The Legislature, through enactment of the Florida Medical Practice Act, recognized that the practice of

medicine is potentially dangerous to the public if conducted by unsafe and incompetent practitioners.

Complaints against physicians may be filed by writing the Department of Professional Regulation or calling the toll free number 1-800-342-7940. Trained complaint analysts screen the complaints. Generally the complaints deal with drug and alcohol abuse and alleged malpractice. Complaints about fees are not under the Board's jurisdiction. Those complaints which appear to have merit and which appear to represent a violation of the Medical Practice Act are passed on to investigators of the Department who go into the field to research the complaint. At this early time, the complaint is confidential.

At the point that the investigative process is complete, the facts are compiled and referred to the Department's Division of Legal Services for evaluation and determination of probable cause. Upon determination of probable cause, the physician is advised of the proposed charges; and an informal conference may be held between the physician and the Departmental prosecuting attorney. At that time, the physician may propose to enter into a Stipulation of Facts and Imposition of Discipline in answer to the allegations against him. If the Secretary of the Department of Professional Regulation has reason to believe that an emergency situation exists, thereby creating an immediate danger to the health, welfare and safety of Florida's citizens, an emergency suspension of the physician's license may be issued.

Ten days after the determination of probable cause, the complaint and the investigative reports become public information and confidentiality is terminated. The physician may dispute the allegations contained in the complaint and elect a formal hearing before a hearing officer of the Division of Administrative Hearings or, the physician may not dispute the allegations and request an informal hearing before the full Board for entry of a Final Order and Imposition of Discipline. Should the physician request a formal hearing, a hearing date is scheduled by the hearing officer at which time both the physician and the Department present evidence in support of their case. This formal hearing is conducted much the same as a case in the civil court system. Following the hearing, a recommended order is rendered by the hearing officer for consideration by the full Board.

In all cases, whether it be the physician who has elected a formal hearing, or the physician who has entered a proposed Stipulation in response to the complaint, the matter is brought before the full Board membership for final disposition and imposition of discipline. Modifications by the Board to a proposed Stipulation must be agreed to by the licensee and the Secretary of the Department. The Board may accept the Recommended Order as proposed or it may choose to decrease the severity of discipline. If the Board chooses to be more severe, then they must review the entire records of the case before them.

Most judgements against physicians who are found guilty of violating the Medical Practice Act involve varying lengths of suspension of their medical license and a period of probation. These probationers are required to appear before the Board at its semiannual meetings. Twenty-four physicians on probation appeared before the Board at its June, 1980 semiannual meeting in Miami.

Other Activities of the Board

1. Several members of the Board of Medical Examiners serve on a joint committee with members of the Board of Pharmacy, the purpose of which is the establishment of the negative formulary in Florida. The negative formulary, which presently consists of 15 drugs, is composed of generic drug type and brand name drug products which are determined by the Boards to demonstrate clinically significant biological or therapeutic inequivalence and which, if substituted, would pose a threat to the health and safety of persons receiving prescription medicine.

2. Three members of the Board of Medical Examiners serve on a joint committee with three members of the Board of Nursing and the Secretary of the Department. The purpose of this Committee, which is established by statute, is to identify and approve acts of "advanced or specialized nursing practice," in addition to the practice of professional nursing which, by virtue of postbasic specialized education, training and experience, are proper to be performed by an advanced registered nurse practitioner.

3. Certification of Physicians' Assistants in Florida.

4. Division of Occupational Therapy.

5. Division of Physical Therapy.

6. Joint authority has been given to the Board of Medical Examiners and the Board of Osteopathic Medical Examiners by the Legislature to make a formal finding as to whether or not laetrile is harmful. A public hearing was scheduled for July 26 and 27, 1980, in Orlando for consideration of the Boards' proposed rules regarding "finding of harmfulness."

Future Meetings of the Board of Medical Examiners

December 5-7, 1980 - Semiannual Meeting of the Board of Medical Examiners, Orlando.



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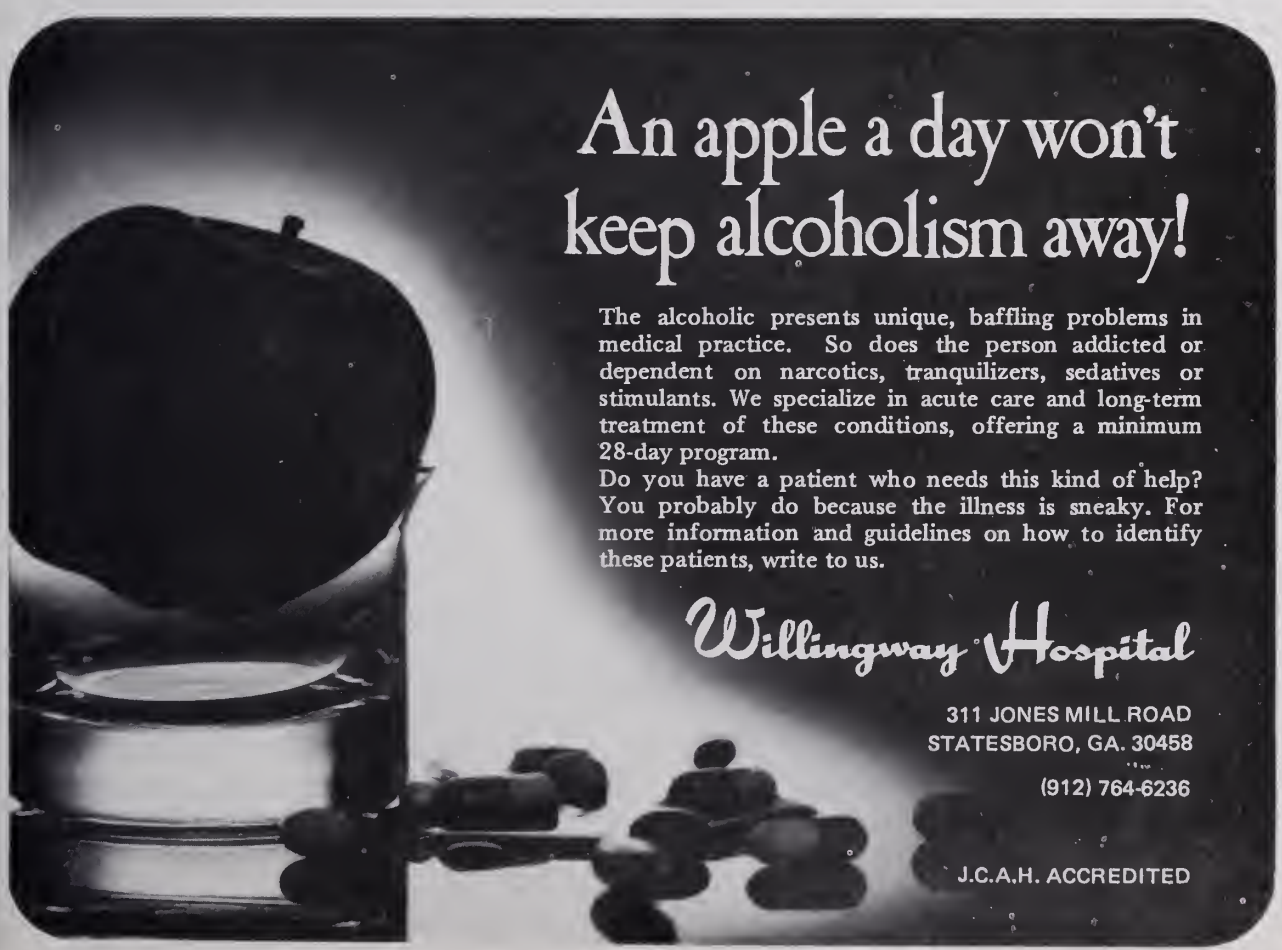
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October 29 and 30, 1980 — Sexual Problems in Medicine — Category I AMA Accreditation — 12 credit hours. Registration Fee — $50. for Practicing Physicians. Guest Faculty will include MASTERS/JOHNSON.

November 10-14, 1980 — Sixth Annual Pan American Medical Seminar — Category I AMA accreditation — 23 credit hours. Registration Fee $180. for Practicing Physicians. FEDERICO R. JUSTINIANI, M.D. — Program Chairman. Totally in Spanish for Spanish speaking physicians.

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J.C.A.H. ACCREDITED

FMA's Legislative Program Geared Up for the Challenges of the 80s

Francis C. Coleman, M.D.
and Donald S. Fraser Jr.

After demise of the mediation panel concept by ruling of the Florida Supreme Court, the probability of a renewed crisis in the professional liability arena again became imminent. The immediate aspects of this crisis were averted by passage of the Recovery of Costs bill by the legislature. This victory was accomplished by the dedicated efforts put forth by the key contact physician system, FMA Auxiliary, local county medical societies and individual members through the coordinated efforts of your FMA Council on Legislation. We are particularly indebted to Francis C. Coleman, M.D., for his untiring efforts. Only by intensification and continuation of this coordinated legislative effort will we be able to translate the successes of this past year into similar victories in the future.

Louis C. Murray, M.D.
Chairman
Council on Legislation

The 1980 legislative efforts of the FMA were extremely successful, with positive results being achieved on all priority goals. Paramount was passage of the recovery of costs and attorney fees legislation (CS/SB 762). While this consumed a majority of the attention of physicians and Auxiliary leaders, it is important to realize that there were 74 other bills in the House and Senate that also required priority efforts from staff and consultants. This involved extensive research, preparation of amendments, vote counts, testimony and communication with county medical societies. We are fortunate to have developed a legislative capability to deal with such a large number of varied medical issues.

With the knowledge that the 1980s would present severe challenges to medicine, the FMA Council on Legislation has undertaken an ambitious program to significantly expand the number of physicians and wives involved in legislative activities and to improve communication with them. This program, which was developed as a result of conferences with the Board of Governors and Auxiliary leaders, is being carried out through the leadership of the Field Office Directors. The principal means identified to accomplish this are an increased and more responsible role for the Auxiliary and improved communication with CMS leaders and key contact physicians. Also, of significance are actions being taken to improve coordination with specialty group legislative activities.

The specific goals to accomplish these objectives were established following indepth interviews with selected legislators, CMS executives, CMS legislative chairmen and Auxiliary legislative representatives. This process was then followed by workshops in each county medical society in order to inform members and Auxiliary leaders and receive additional critique on improvements in the outlined program. These sessions were extremely beneficial, resulting in many of the suggestions being incorporated into our final plans.

Council on Legislation Focal Point for Action

The FMA Council on Legislation is responsible for coordinating and implementing activities of the Association which pertain to state and national legislation. The Council is composed of two operating committees: a Committee on State Legislation and a Committee on National Legislation. Through these committees, the Council serves as a primary focal point not only for carry-

Dr. Coleman is Vice Chairman of the Florida Medical Association's Council on Legislation and Chairman of the Committee on National Legislation. Mr. Fraser is Director of Legislative Affairs for the Association.

ing out the legislative goals of the FMA but for developing recommended FMA positions on state and national issues. In accomplishing this task, the Council relies to a large degree on the input received from county medical societies and their legislative committees.

The Council plays a major role in development of legislative goals each year through the requirement that it present a recommended program to the Board of Governors at its fall meeting. In order to have a program that can responsibly represent physicians throughout the state, the Council begins meetings in the summer with input solicited from county medical societies, specialty organizations, and members of the FMA Auxiliary.

Particularly important in the decision process is the input from CMS legislative chairmen. If this is given on a timely basis, it allows the Council and the Board of Governors to adjust their priorities and positions based on new information developed from the local input.

Decisions Start With County Medical Society Committee

The CMS legislative committee is not only the foundation for beginning the development of Association policy on legislative issues but is the most important vehicle the FMA has for maintaining the dialogue and personal contact with individual members of the Congress. County medical societies are asked to provide a key contact physician for each legislator and to assure that discussions are carried out on the Association's legislative program for the current year.

A critical part is the report to the FMA Capital Office with regard to a legislator's leanings on a particular issue. These local reports form the basis upon which the strategy for implementation of legislative goals are determined. Without "adequate intelligence" from the local level, the Capital Office is seriously hampered in developing appropriate strategy. Through the work carried out by the county society committee members and leaders of the Auxiliary, the FMA has been successful in maintaining this local legislative relationship.

Key Contact Physician Cornerstone for Success

The key contact physician has proven to be the cornerstone for success in the Association's legislative efforts. In addition to regularly participating in meetings of the CMS legislative committee, the key contact physician is asked to maintain continuous contact with the FMA Capital Office. The Key Contact Physician Program builds the basic trust and confidence in objectives of the FMA that must exist as a foundation for the legislators' understanding, particularly during the "hectic" days that the legislature is in session. In order to strengthen communications, workshops have been held throughout the state with key contact physicians and members of CMS legislative committees.

FMA Auxiliary An Active Partner in the Process

The 1980 legislative efforts clearly demonstrated the critical role of the FMA Auxiliary in achieving our objectives. Members of the Auxiliary have been meeting during the past year, at both the state and county medical society level, to develop specific goals for a more meaningful role in the FMA's legislative program. Auxiliary members have not only participated in county society workshops but have conducted separate training sessions for their members through the leadership of the FMA Field Office Directors.

The FMA Board of Governors, in recognizing the increased role for the Auxiliary, has suggested that Auxiliary members be placed on the legislative committees for each county medical society and that they assist in communication with CMS members and allied groups. In addition, the Board of Governors has approved the appointment of an Auxiliary member to assist the national key contact physician in coordinating his activities with CMS and Auxiliary leaders in each of Florida's congressional districts.

An important part of this program, which has been implemented in each county medical society, is the legislative "LEGS" alert system. This is a mechanism in which Auxiliary members expedite communication on legislative issues with members of the Auxiliary and CMS leaders and hospital staffs.

Increased Coordination with Specialty Groups

In order to increase the capability of both the FMA and the individual specialty groups, we have improved coordination between the legislative programs of the various organizations. Meetings have been held with representatives of FMA recognized specialty groups to develop detailed guidelines. The Council has recognized the need for the FMA to lend active support to the priority legislative goals of the individual specialty groups. As these goals are identified, the Board of Governors is asked to authorize the necessary Capital Office and key contact physician activities. Regular meetings are carried out between the staff of the FMA and lobbyists for the various specialty groups. These insure that all parties are updated on the current legislative status and that such things as selection of sponsors, introduction of bills, etc., are coordinated. An important result of these activities will not only be greater FMA attention to specialty group legislative goals but an increased involve-

ment by specialty group lobbyists in support of the priority objectives of the FMA.

A great deal has been accomplished during the past year in improving communication and working relationships with county medical societies, FMA Auxiliary and recognized specialty groups. There is much yet to be done, but initial results clearly indicate the wisdom of maintaining the pattern that has been established. A significant and integral part of the success of these efforts will be the continued and even increased involvement of the FMA Field Office Directors.

Your input and criticisms are welcomed as these plans and programs are updated and reviewed for the coming year.

● Dr. Coleman, Suite 21, 4600 North Habana Avenue, Tampa 33614.

Peer Review Its Role in Organized Medicine

Charles B. Mutter, M.D.

The concept of Peer Review and its application is as old as the inception of medicine. Physicians have taught the art and science of healing to students who later evolved as teachers, and in the process professional services have undergone continual evaluation.

Interns and residents are guided by physicians to enhance skills and experience, and this endeavor toward excellence is perpetuated through continuing medical education courses which are a continuum of medical training and are now mandated for relicensure in some states.

Peer guidance and review are evidenced in many areas of medical practice including new case conferences, medical and surgical updates, problem case conferences, grand rounds, and morbidity and tissue conferences. Each of these activities and others like them exist to enhance quality care and establish acceptable principles of medical practice.

Some may view the role of Peer Medical Utilization Review (PMUR) as another form of government intervention, but an understanding of the process and its application is vital if the physician is to derive the constructive benefits the system was designed to provide. To accomplish this, the State PMUR Committee, with the approval of the FMA Board of Governors, has prepared a series of articles to explain the PMUR process and its constructive application. These informative articles will offer preventive guidelines to help the individual physician avoid future peer review, and enable physicians who have become subject to peer review to understand and derive its benefits.

When Medicare was conceived, Congress envisioned a socialized system financed by the Government which would render quality care to the elderly. This concept failed to recognize the fact that almost all physicians in the country were already rendering high quality care to senior citizens and often not billing indigent patients. Congress was not cognizant of the cost of this care until Medicare granted physicians the legal right to bill and collect fees from the Government for these services.

Reluctant to admit oversight in the calculation of the cost of the Medicare program, Congress sought a scapegoat. The solution came in the form of utilization committees established without adequate and proper medical input. When the inefficacy of this system was realized, a second solution was launched — a propaganda campaign accusing doctors of "gouging."

It was finally ascertained that doctors were the only

Prepared under the auspices of the FMA Committee on Peer Medical Utilization Review.

Dr. Mutter is a psychiatrist in private practice in Miami, and is Chairman of the PMUR Committee.

ones capable of properly establishing guidelines and controlling medical costs, and the peer review process as we know it was subsequently established. The early organization of peer review was carefully scrutinized by the Government with the intention of imposing controls if the infant system failed in its attempts to establish reasonable guidelines for medical necessity, quality care and reasonable cost.

Many physicians believed this surveillance was an attempt to sell the doctor short, and decided early on that they wanted no part of this "entrapment." The guiding forces of organized medicine, however, realized an important truth: only doctors can teach and guide their fellow physicians, and only peers can objectively evaluate the pattern of practice of their colleagues.

Peer Review is not part of the adversary system and therefore attorneys and court reporters are not permitted. The process attempts to establish the approrpriateness of services rendered without judging guilt or innocence. This will be explored further in a future article.

Oftentimes, very competent physicians are referred to peer review. There is a logical explanation for this which will also be the subject of a future article. Other future articles in this series will discuss the PMUR process in detail, the computer and in-house review, the role of the county and state committees, and how the physician can employ these insights to enhance his quality of care and avoid the problems encountered in peer review.

• Dr. Mutter, Suite 308, 3661 South Miami Avenue, Miami 33133.

Buy Citrus and Seafood Support the Florida Medical Foundation

Florida Medical Foundation is a nonprofit, charitable, scientific and educational organization founded and sponsored by the physicians of Florida. The Foundation is directed by the Association's Board of Governors.

The objectives of the Foundation are to:

1. Improve the health and medical care of the people of Florida.
2. Promote and sponsor medical research.
3. Sponsor graduate and postgraduate medical education.
4. Aid medical students needing assistance.
5. Assist deserving indigent or destitute physicians and/or their families.

The Foundation is exempt from Federal income tax. Contributions are deductible.

Major fund raising efforts this year include:

1. A one week luxury tour and Medical Seminar to Monte Carlo on the French Riviera which took place October 1-9, and was arranged by Intrav, a company with an excellent reputation for successful trips. Additional trips are being considered.
2. Continued mail order dales of seafood and citrus — excellent products of the world's largest packer and shipper of Florida Gift Fruit. The quality will continue to be unexcelled. For further information, a free catalogue and ordering information, write to the address below and include a #10 envelope.

If I can assist you in any way, please let me hear from you.

Mrs. C. Brooks Henderson, Chairman
Florida Medical Foundation, 1980-1981
1610 S.E. 22nd Avenue
Ocala, Florida 32670
Telephone: (904) 629-1211

FMA Headquarters

The Florida Medical Association has moved into its new headquarters office in Jacksonville located at 760 Riverside Avenue. The move was effected in early August.

The new building, a contemporary two-story brick and block structure, affords approximately 10,000 square feet of office space which adequately meets the current and foreseeable needs of the Association. The Florida Physicians' Insurance Reciprocal purchased the building a year ago and it was obtained by the FMA in a lease purchase agreement. FMA expects to purchase the building from the Reciprocal by December 31, 1980.

The former Headquarters Office, located at 801 Riverside Avenue, was initially purchased for investment purposes and not for long term occupancy. FMA realized over $600,000 profit from a $300,000 cash investment in less than three years by selling the building to Barnett Bank Trust Company for use as its statewide headquarters.

The FMA also owns its Capital Office building at 100 East College Avenue in Tallahassee, and maintains rented offices for the Central Florida Office in Tampa at the Host International Hotel (Suite A-21) and for the South Florida Office in Miami at the Central Bank Building (Suite 600).

As a matter of historical background, the FMA (originally called the Medical Association of the State of Florida) was founded by a core group of 10 physicians in 1874 in the Jacksonville home of Abel S. Baldwin, M.D.



The Jacksonville Home of Abel S. Baldwin, M.D. (1874)

The organization was chartered with 25 members. By 1904 the membership had grown to 170, doubling by 1914. In the decades to follow, FMA membership continued to grow at a steady and oftentimes remarkably accelerated rate. Today FMA ranks sixth in size among State Medical Associations with a current membership of 12,937 members.

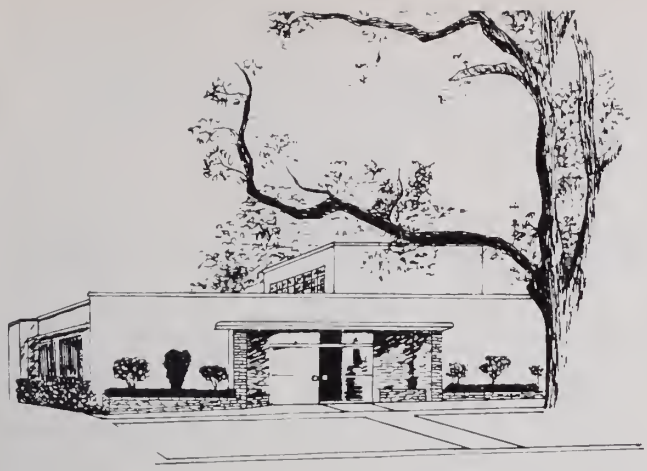
During its first 52 years of existence, all the financial records and correspondence were stored in the homes of the Secretary and Treasurer. The elected secretary served as stenographer and record keeper, and the elected treasurer served as business manager and bookkeeper. In 1890, these two offices were combined.

By 1926, the membership of the Association had grown considerably, and the responsibilities of the secretary/treasurer had increased to such an extent that a resolution was adopted to hire a part-time business manager in the person of Stewart Gordon Thompson, D.P.H. Director of Vital Statistics of the State Board of Health. A room in the State Board of Health building was rented and the first headquarters office of the FMA was thus established. Under Dr. Thompson's direction, records which had formerly been kept in the homes of members were gathered, with the exception of those which had been destroyed by the Jacksonville fire of 1901, with the assistance of Webster Merritt, M.D. Dr. Thompson was also able to assemble a complete file of the FMA Proceedings (then known as the Transactions) and *The Journal* (which had been initiated in 1914).

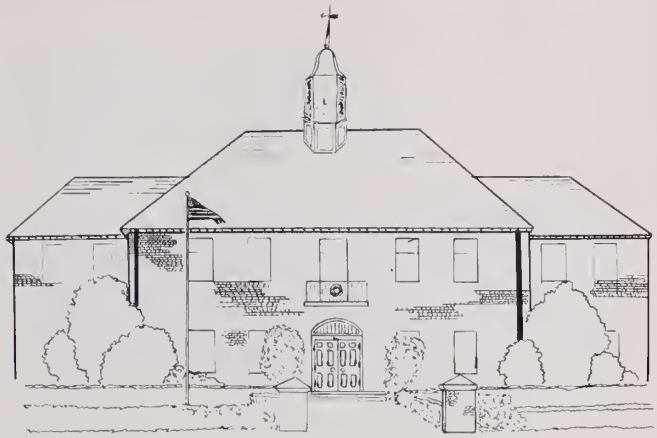
During these early times, State Board of Health clerical personnel were hired as needed and given overtime pay to keep the records of the Association.

As the Association grew so did the need for space and in 1932 the office was relocated to the Florida Theater Building at a cost of $15 per month. A full-time stenographer was employed and in 1937 Dr. Thompson assumed the position of full-time Managing Director, a position he held until his death in 1953. Following Dr. Thompson's death, Mr. Ernest Gibson who had served as his assistant was named Acting Managing Director and in 1958 former Public Relations Director, W. Harold Parham, D.H.A., was appointed to the newly created position of Executive Director.

During this time, FMA's membership continued to



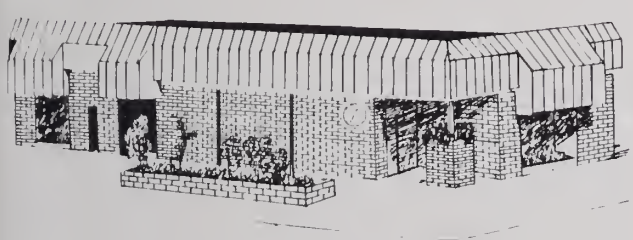
735 Riverside Avenue
(1956—1977)



801 Riverside Avenue
(1977—1980)

grow and a Building Committee (under the direction of Edward Jelks, M.D.) began actively seeking a suitable site for an expanded FMA Headquarters. In 1956 it was announced that a location had been purchased and construction was proceeding. In September of that year, the new FMA Headquarters building at 735 Riverside Avenue was dedicated.

The increasing complexities of organized medicine during the 60's and 70's resulting in burgeoning FMA activities and programs necessitated additions to the building in 1960 and 1975. In 1977 the FMA moved its headquarters one block South to an attractive two-story red brick building located on prime river front property.



Capital Office, Tallahassee
(Operational since 1969)

The purchase of the building, which was previously owned by Commercial Union Insurance Company, was made possible by a variety of circumstances including difficulties that the overall insurance industry had experienced in recent years and consolidation of offices by Commercial Union as well as recessionary pressures. The excellent purchase price made this an excellent investment opportunity for the Association and was not intended for long-term occupancy. The FMA property at 735 Riverside was sold for more than its book value. It is interesting to note that the current headquarters building and the two previous buildings occupied by the FMA are all located within a one-block radius.

Under the direction of Dr. Parham, who now serves as Executive Vice President of the FMA, field offices were opened in Miami and Tampa (1977) complementing the Capital Office in Tallahassee which has been in operation since 1969. These additions placed FMA offices in all major areas of the state, allowing the Association to provide expanded services to FMA members, component County Medical Societies and the public.

Donald C. Jones
Executive Director

FMA Policy on DMSO

(Editor's Note: Due to recent televised reports on DMSO, the interest in the drug in Florida has increased substantially. In response to the many requests for information, FMA President T. Byron Thames, M.D., released the following letter to editors of Florida newspapers.)

September 4, 1980

Dear Editor:

The Florida Medical Association would appreciate an opportunity through this section of your newspaper to state the Association's position and furnish what information we have available about the drug dimethyl sulfoxide, commonly known as DMSO.

DMSO is essentially the oil liquid which holds tree cells together. It is a by-product from the manufacture of paper. Research on the drug has been taking place since the early 1960's.

In April of 1978 the drug was approved by the Food and Drug Administration for the symptomatic relief of interstitial cystitis only. On Sunday, March 23, 1980, the CBS television program "60 Minutes" broadcast a segment on DMSO which featured claims for the drug in treating symptoms other than that for which it has been cleared by the FDA. The program also stated that the drug was available in Oregon and Florida.

Since that time an almost daily stream of inquiries both by letter and telephone have been directed to our state headquarters in Jacksonville. Most of the in-state queries are from the media while the majority from out of state are individuals seeking a physician to provide them with this perceived "miracle cure" for a variety of symptoms.

Without an approved new drug application, the drug cannot be marketed or distributed in Florida for indications other than the treatment of interstitial cystitis. However, legally, a doctor may prescribe an approved drug for other indications.

The Florida Legislature passed a law in 1978 which permits a physician to use DMSO after advising the patient of alternative treatment and any potential for cure. The law requires that upon request to the physician for DMSO treatment, the patient shall sign a written release of liability to the physician and when applicable, the hospital or facility. The physician shall inform the patient in writing if DMSO has been approved by the FDA for the disorder for which it is being prescribed.

The Florida Medical Association does not condone going outside of the approved and responsible mechanism for the introduction of a new drug. As a matter of fact, physicians covered by professional liability insurance under the FMA-sponsored plan have been warned regarding the drug. They will not be covered by the plan if they use DMSO for any symptom other than the relief of interstitial cystitis for which, as previously stated, it is approved by the FDA.

At the same time, FMA does encourage its physician members who are interested, to take part in the FDA investigational program in this and other areas. Assistance is available for obtaining from the FDA an Investigational New Drug Application (IND) plus sterile non-pyrogen DMSO solution. In order to participate in this research, the physician must agree to keep the necessary records. The DMSO solution will be supplied free of charge and assistance given to the physician in developing the necessary protocol.

As to the law passed during this year's legislative session allowing for the manufacture, distribution, and sale of a DMSO ointment in Florida, FMA has no direct knowledge and no participation in any way in this matter. We are informed by officials in the Department of Health and Rehabilitative Services that they are in the process of developing rules and regulations to govern the manufacture of such a product and that at this time one formal application to do so has been submitted.

FMA does not have, nor do we plan to develop, a list of physicians and/or clinics who are going outside of established protocol and administering the drug to patients. Not only would this be contrary to our policy of safeguarding the public's health, but could place FMA in a libelous position. Consumer inquiries concerning DMSO or any other new experimental drugs should be directed to the FDA Bureau of Drugs, Advisory Opinion Board HFD 35, 5600 Fishers Lane, Rockville, Maryland 20852.

This summarizes FMA's position and information we have on the subject. We appreciate and are thankful for your assistance in making it available to the public.

T. Byron Thames, M.D.
President
Florida Medical Association



Oscar Sussman, D.V.M., M.P.H., J.D. . . . has been named Associate Epidemiologist/Veterinarian on the epidemiology staff of the Health Program Office of the Department of Health and Rehabilitative Services. He will serve under **Robert A. Gunn, M.D., M.P.H.**, State Epidemiologist. Dr. Sussman will assume general responsibility for consultation and program development for zoonotic diseases including rabies, brucellosis, psittacosis and leptospirosis. He will also be available to assist as needed in the Department's environmental health program regarding foodborne illness.

He obtained his D.V.M. degree from Michigan State University in 1940. In 1947, he was awarded an M.P.H. degree from Yale University School of Medicine. He received his LL.B. degree and a J.D. degree in Administrative law from Seton Hall University.

The Committee of One Thousand . . . has selected **Emanuel M. Papper, M.D.**, Vice President for Medical Affairs and Dean of the University of Miami School of Medicine to serve on its executive board. The national group, composed of distinguished physicians and scientists, serves as a board of inquiry to determine whether the United States is too slow in approving the use of effective drugs already available in Europe.

William L. Stewart, M.D. . . . has joined the University of Florida College of Medicine as Chairman of the Department of Community Health and Family Medicine. His last previous position was Professor and Chairman of the Department of Family Practice, Southern Illinois School of Medicine.

Dr. Stewart received his M.D. degree from Johns Hopkins University and is on the editorial board of *The Journal of Family Practice*.

Twenty Florida physicians . . . are among the latest group of 179 doctors in the United States to be admitted to Fellowship in the American College of Cardiology. **C. Richard Conti, M.D.**, of Gainesville, ACC Governor for Florida, identified them as:

Earl B. Barron, M.D., Hollywood; **Julian L. Berman, M.D.**, Coral Springs; **William B. Blanchard, M.D.**, Gainesville; **Ronald L. Blankstein, M.D.**, and **Anne M. Garami, M.D.**, both of Miami Beach; **Chandana Bopitiya, M.B.B.S.**, Venice; **William T. Brown, M.D.**, and **Joshua Kieval, M.D.**, both of Miami; and **Michael A. Chizner, M.D.**, and **Bart T. Heffernan, M.D.**, both of Fort Lauderdale.

Candido F. Diaz-Cruz, M.D., and **Dean H. Roller, M.D.**, both of Coral Gables; **Kay E. Gilmour, M.D.**, and **Paul H. Dillahunt II, M.D.**, both of Jacksonville; **Richard G. Kachel, M.D.**, West Palm Beach; **Poovambur S. Krishnamurthy, M.B.B.S.**, Perry; **Patterson W. Moseley, M.D.**, and **Arthur S. raptoulis, M.D.**, both of Orlando; **Steven L. Marshall, M.D.**, North Palm Beach; and **Elihu York, M.D.**, Pensacola.



Richard Dozier, M.D., left, and Laurie Dozier Jr., M.D., right, with their father Laurie Dozier Sr., M.D.

Laurie Dozier Sr., M.D., of Tallahassee . . . was honored by the Capital Medical Society on July 14 for his 52 years of medical practice in Tallahassee. CMS President William Price, M.D. presented Dr. Dozier with a resolution from the Society expressing the respect and appreciation of the members for services rendered to medicine and the community. Dr. Dozier is retiring from practice, but his sons, Internist **Laurie Dozier Jr., M.D.**, and Allergist **Richard M. Dozier, M.D.**, will continue the family tradition.

Kenneth C. Kiehl, M.D., of Sarasota . . . was installed as President of the Florida Academy of Family Physicians at the Academy's Annual Meeting at Marco Island in June.

He succeeds **Charles Dunn, M.D.**, of Miami, who becomes Chairman of the Board of Directors. Other officers include:

Arthur Eberly Jr., M.D., Pompano Beach, President-Elect; **Richard Dodd, M.D.**, Daytona Beach, Vice President; and **Guy T. Selander, M.D.**, Jacksonville, Secretary-Treasurer.

Jose Strauss, M.D., of Miami . . . has been elected President of the Pediatric Society of Greater Miami. Dr. Strauss is Professor of Pediatrics and Director of Pediatric Nephrology at the University of Miami.

Arnold L. Tanis, M.D., of Hollywood . . . has been awarded a Citation for Public Service from his alma mater, the University of Chicago. The citation, awarded May 17, 1980, cites the Hollywood pediatrician for his leadership in civic, social and religious activities, "his creative citizenship and exemplary leadership in voluntary activities which have benefited society and have reflected credit on the University and its alumni."

Six Florida physicians . . . have been elected to Fellowship in the American College of Radiology. They will be formally received at the College's Annual Meeting in New Orleans, September 21-25.

The new Florida Fellows were identified as:

Donald M. Bryan, M.D., Rockledge; **Irwin L. Entel, M.D.**, Dunedin; **Maurice M. Greenfield, M.D.**, Coral Gables; **John H. Kathe, M.D.**, Biscayne Park; **Martin L. Silbiger, M.D.**, Tampa; and **Jack Widrich, M.D.**, Miami Beach.

Jean Bennett, M.D., of Clearwater . . . has been named a Distinguished Alumnus of the University of Florida. A pediatrician, Dr. Bennett is President of the UF Medical Alumni Association and is chief of fund-raising for the Association.

Dr. Bennett was a member of the College of Medicine's first graduating class in 1960.

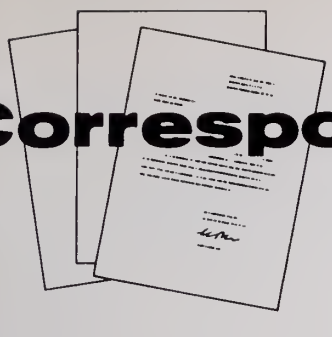
James Ryan Chandler, M.D., of Miami . . . was installed as president of the American Society for Head and Neck Surgery for 1980-1981 at the Society's meeting in Palm Beach last April. Dr. Chandler is Chairman of Otolaryngology at the University of Miami School of Medicine.

Twenty-Five Years Ago

In *The Journal of the Florida Medical Association* for October 1955:

"Medical Aspects of Jaundice" and "Surgical Aspects of Jaundice" were planned as titles of papers to be presented at the scientific assemblies of the four FMA Medical District meetings in Fort Lauderdale, Lakeland, Gainesville and Pensacola . . . **L. L. Parks, M.D.**, Secretary of the Florida Cancer Council, reported that Florida had 19 tumor clinics as of October 1955 . . . About 400 physicians were expected to attend the Fifteenth Annual Meeting of the Gulf Coast Clinical Society in Pensacola, October 27-28 . . . **Frank G. Slaughter, M.D.**, of Jacksonville, addressed a civic club on "The Usefulness of Useless Knowledge" . . . Employees of the State Board of Health honored **Wilson T. Sowder, M.D.**, on his 10th anniversary as State Health Officer . . .

And so it was in Florida medicine 25 years ago this month. — E.D.H.



Correspondence

"FIVE FOR FLORIDA'S FUTURE"

To the Editor: Thank you for the opportunity to share with the members of the Florida Medical association my views on the five constitutional amendments that will be placed before Florida voters on October 7.

Briefly, the amendments would:

- permit property tax exemptions for renewable energy devices, such as solar heating and cooling systems;
- authorize state revenue bonds to finance or refinance housing, including single family and rental apartments;
- allow residents of individual cities or counties to vote for local option property tax incentives for new or expanded industries, and community development;
- increase homestead exemption on city and county taxes to $15,000 in 1980, $20,000 in 1981 and $25,000 in 1982 and thereafter;
- permit the Legislature to eliminate property taxes on business inventories.

These amendments would assist in meeting three of Florida's most pressing needs. A positive incentive would be given for Floridians to invest in solar and other renewable devices which will save energy. Economic development will be stimulated as Florida becomes more competitive in its efforts to encourage existing businesses to expand and attract new ones. An additional source of financing for housing, at no cost to the Florida taxpayer, will be provided to make housing more available and the homestead exemption increased to make it more affordable in the face of spiraling inflation. Passage of these amendments will send a powerful message of our commitment to a prosperous Florida with a high quality of life for all its citizens.

Each of these proposed amendments deserves the support of Floridians, and I urge your careful consideration and support.

Bob Graham
Governor

FAMILY PRACTICE ISSUE

To the Editor: I have just finished devouring the September special issue. And I mean devouring — with gusto! I serve as Editor of our State Family Practice Journal *"The Bulletin"*, and have been a member of the American Academy of Family Physicians and the Connecticut Academy of Family Physicians from Day One. So you can imagine how much pleasure I derived from seeing an entire issue of a state journal devoted to family practice.

Before I do any more slobbering let me tell you how I enjoyed your "Reflections" (page 799, September issue). We here in Connecticut are also waging the unending struggle to convince our colleagues on the need for membership in the AMA. I am sure you have heard all the boring, lame-brain excuses for not joining. Keep after them.

And now to the special issue.

The task of coordinating so many articles from so many sources, physicians, allied professions, advertisers, etc., is gigantic.

It was done with an attention to detail and an exacting precision that merits the highest praise. Bravo! Bravo! Bravo!

I intend to circulate the copy you have sent to as many Connecticut colleagues as possible.

Again, my sincerest praise to you, to Dr. Plyler and to your entire editorial staff and contributors.

D. William Pasquariello, M.D.
Bridgeport, Conn.

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Book Reviews

Book Review Editor — F. Norman Vickers, M.D.

Applied Therapeutics for Clinical Pharmacists, Second Edition, Edited by Mary Anne Koda-Kimble, Pharm.D., Brian S. Katcher, Pharm.D., and Lloyd Y. Young, Pharm.D. 944 Pages. Price $31.50. Applied Therapeutics, Inc., San Francisco, 1978.

Forty-five contributors collaborated in the development of this important book on applied therapeutics. The purpose of the book is to present principles of appropriate clinical application of Pharmacology and pharmacokinetics to specific disease states and patient problems. Relevant case histories, pertinent questions and well-referenced responses are employed to illustrate the principles and nature of rational decision making process in clinical therapeutics. The book is divided into forty-three chapters covering most disease states and disturbance of normal body function, such as congestive heart failure, diabetes mellitus, diseases of the thyroid, fluid and electrolyte imbalance, etc. Each of the 43 chapters is devoted to a particular disease state or therapeutic problem, except the first and second chapters which are devoted to interpretation of clinical laboratory tests, and clinical pharmacokinetics.

The chapters generally begin with a good overview of the pathophysiology of the disease state. They employ appropriate case studies to illustrate the problems, abnormalities, or lesion resulting from the disease state. Then they synthesize a rational approach to the problem. Relevant questions and very well referenced answers are employed to achieve these objectives.

As in any book written by several authors, some chapters flow better than others and are therefore more pleasant to read. In addition, although the question and answer approach was helpful in highlighting and answering specific and genuine therapeutic questions, some readers will find that some other questions they may have liked to ask were not asked and therefore not covered in the book. However, authors don't generally attempt to cover every point about every topic in a single volume.

The book was primarily written for educating clinical pharmacists, however, physicians, medical students, nurse practitioners and other members of the health care team will find it useful.

Peter U. Nwangwu, Pharm.D., Ph.D.
Tallahassee

Cry Babel: The Nightmare of Aphasia and a Courageous Woman's Struggle to Rebuild Her Life by April Oursler Armstrong. 252 Pages. Price $8.95. Doubleday & Company, Inc., Garden City, New York 1979.

Aphasia, a dreadful handicap for ordinary people, can become even more terrifying to those among us who are erudite, educated and communication-oriented. So it was with the author afflicted in her prime with a ruptured cerebral aneurysm.

The book may interest physicians inasmuch as the patient's views concerning medical specialists, rehabilitative therapy and family ties are related by a sensitive observer. A woman of strong religious conviction, this feature of her personality permeates much of her experience.

The popular press has recently had several successful books about illness written by patients and each can give the physician some rewarding insights. This volume compares well to others of the genre.

H. W. Eichenbaum, M.D.
St. Petersburg

Books Received

Receipt of the following books is acknowledged.

The Chemistry of Human Behavior by Herbert L. Meltzer, Ph.D. 261 Pages. Illustrated. Price $17.95 (cloth). Nelson-Hall Publishers, Chicago, 1979.

Annual Review of Neuroscience with 31 contributing authors. 555 Pages. Annual Reviews, Inc., Palo Alto, California, 1979.

Norethindrone, The First Three Decades edited by Mary Jean Pramik. 100 Pages. Syntex Laboratories, Palo Alto, California, 1978.

How To Improve Your Child's Behavior Through Diet by Laura J. Stevens and Rosemary B. Stoner. 346 Pages. Price $9.95. Doubleday & Company, Inc., New York, 1979.

The Vitamin Book by Rich Wentzler. 224 Pages. Price $4.95. Doubleday & Company, Inc., New York, 1979.

Cooking Creatively for Your Diabetic Child by Caroline Hastings Babington. 224 Pages. Price $8.95. Doubleday & Company, Inc., New York, 1979.

Review of Physiological Chemistry by Harold A. Harper, Ph.D., Victor W. Rodwell, Ph.D., and Peter A. Mayes, Ph.D., D. Sc. 702 Pages. Price $14.50. Lange Medical Publications, Los Altos, California, 1977.

Clinical Anxiety/Tension in Primary Medicine: Proceedings of a Colloquium, Washington, D.C., Excerpta Medica, Lawrenceville, N.J.

Handbook of Pediatrics by Henry K. Silver, M.D.; C. Henry Kempe, M.D. and Henry B. Bruyn, M.D. 730 Pages. Price $9.50. Lange Medical Publications, Los Altos, California, 1980.

Handbook of Poisoning, Tenth Edition, by Robert H. Dreisback, M.D. 578 Pages. Price $9.50. Lange Medical Publications, Los Altos, California, 1980.

General Ophthalmology, Ninth Edition, by Daniel Vaughan, M.D. and Taylor Asbury. 410 Pages. Price $15.00. Illustrated. Lange Medical Publications, Los Altos, California, 1980.

Controlling the Use of Therapeutic Drugs, An International Comparison, edited by William M. Wardell. 263 Pages. Price $4.75. Illustrated. American Enterprise Institute for Public Policy Research, Washington, D.C., 1978.

Annual Reviews Reprints: Immunology, 1977-1979, compiled by Irving Weissman. 466 pages. Illustrated. Annual Reviews, Palo Alto, California, 1980.

The Diabetic Gourmet, Revised Edition by Angela Bowen, M.D. 193 Pages. Price $10.95. Harper and Row, New York, 1980.

Current Pediatric Diagnosis and Treatment by C. Henry Kempe, M.D., Henry K. Silver, M.D., and Donough O'Brien, M.D. 1122 Pages. Illustrated. Price $20.00. Lange Medical Publications, Los Altos, California, 1980.

Basic First Aid, Second Edition by the American Red Cross. Four volumes, 790 Pages. Price $5.25. Illustrated. Doubleday & Company, Inc., New York, 1980.

Shocktrauma by Alan Doelp and John Franklin. 246 Pages. Price $9.95. St. Martin's Press, New York, 1980.

Review of Medical Microbiology, 14th Edition by Ernest Jawetz, Ph.D., M.D., Joseph L. Melnick, Ph.D. and Edward A. Adelberg, Ph.D. 593 Pages. Price $14.00. Illustrated. Lange Medical Publications, Los Altos, California, 1980.

Handbook of Obstetrics & Gynecology, Seventh Edition by Ralph C. Benson, M.D. 808 Pages. Price $10.00. Illustrated. Lange Medical Publications, Los Altos, California, 1980.

Breast Self-Examination by Albert R. Milan, M.D. 125 Pages. Paperback. Price $3.50. Workman Publishing Company, New York, 1980.

Handbook of Obstetrics and Gynecology by Ralph C. Benson, M.D. 808 Pages. Paperback. Price $10.00. Lange Medical Publications, Los Altos, California, 1980.

Ceasarian Childbirth, A Handbook for Parents by Christine Coleman Wilson and Wendy Roe Hovey. 297 Pages. Paperback. Price $6.95. Doubleday and Company, Inc., New York, 1980.

Emergency Handbook by Peter Arnold with Edward L. Pendagast Jr., M.D. 250 Pages. Price $11.95. Doubleday & Company, New York, 1980.

Whole Again by Lee Whipple. 232 Pages. Price $9.95. Caroline House Publishers, Inc., Ottawa, Illinois, 1980.

Footnotes by Michelle Arnot. 164 Pages. Paper. Illustrated. Price $5.95. Doubleday & Company, Inc., New York, 1980.

Basic and Clinical Immunology by H. H. Fudenberg, M.D., Daniel P. Stites, M.D., Joseph L. Caldwell, M.D., and J. Vivian Well, M.D. 782 Pages. Paperback. Illustrated. Price $17.50. Lange Medical Publications, Los Altos, California, 1980.

Microbial Diseases — Notes, Reports, Summaries, Trends compiled by Carl W. May. 322 Pages. Paperback. Illustrated. William Kaufmann, Inc., Los Altos, California, 1980.

Sound Sleep by Quentin R. Regestein, M.D. 208 Pages. Illustrated. Price $10.95. Simon and Schuster, New York, 1980.

What's Your Diagnosis

Purpura

(Editor's Note: The following contribution to "What's Your Diagnosis?" was submitted by Neil Abramson, M.D., who specializes in Hematology and Medical Oncology in Jacksonville. If you have encountered an unusual case you believe may be appropriate for inclusion in this feature of *The Journal*, please submit a brief report of the case and your diagnosis to: The Editor, *Journal of the Florida Medical Association, Inc.*, Post Office Box 2411, Jacksonville, Florida 32203.)



A 42-year-old white female was admitted to the intensive care unit with respiratory insufficiency, cardiovascular compromise, urticaria, and thrombocytopenia (90,000/mm^3), and abnormal prothrombin and partial thromboplastin times.

While in the intensive care unit, the patient was kept at bedrest and in the prone position because of hypotension. Several days after the coagulation abnormalities were reversed, mild thrombocytopenia persisted. A bone marrow was normal, but at the time the test was conducted, purpuric lesions were noted as shown in the above photograph. No other areas of purpura were noted.

Some of the lesions were in proximity to injection sites, but no needle puncture marks were present and parenteral medication was not placed in this quadrant of the buttock.

What's your diagnosis as to the cause of purpura?

During her stay in the intensive care unit, the patient utilized a bedpan for urine and stool elimination, and the areas of purpura corresponded to points of maximal pressure from the bedpan, which functioned as a fulcrum while the patient was in the prone position.

Purpura is a physical finding associated with numerous diseases or conditions, and may be caused by mechanical factors such as in saddle purpura, orthostatic purpura, and the purpura associated with convulsions or vigorous respiratory motion. This example of bedpan purpura occurred because of a pressure phenomenon and a transient coagulation abnormality.

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(diethylpropion hydrochloride NF)

Tenuate Dospan®
(diethylpropion hydrochloride NF) controlled-release

AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.

CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).

WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. *Drug Dependence:* Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. *Use in Pregnancy:* Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children:* Tenuate is not recommended for use in children under 12 years of age.

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

ADVERSE REACTIONS: *Cardiovascular:* Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System:* Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal:* Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic:* Urticaria, rash, ecchymosis, erythema, *Endocrine:* Impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System:* Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous:* A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in midevening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in midmorning. Tenuate is not recommended for use in children under 12 years of age.

OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

Product Information as of April, 1976

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Cayey, Puerto Rico 00633

Direct Medical Inquiries to
MERRELL-NATIONAL LABORATORIES
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References: 1. Citations available on request from Medical Research Department, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M.T., O'Dillon [Oillon], R.H., and Leyland, H.M. A comprehensive review of diethylpropion hydrochloride. In, Central Mechanisms of Anorectic Drugs, S. Garattini and R. Samanin, Ed., New York, Raven Press, 1978, pp. 391-404

Merrell

9-4672 (Y957A)

Overweight may not always be simple... complications can develop*.

Complicated or not...

Tenuate® Dospan® (IV)

(diethylpropion hydrochloride NF)

75 mg. controlled-release tablets



A useful short-term adjunct in an indicated weight loss program.

Overweight patients in certain diagnostic categories often require strict appetite control and a successful program of weight reduction may tend to diminish the incidence or severity of the complications in some patients. Diethylpropion hydrochloride has been reported useful in such patients and while it is not suggested that Tenuate itself in any way reduces the complications of overweight, it may have a useful place as a short-term adjunct in a prescribed dietary regimen. **Tenuate should not be administered to patients with severe hypertension; see additional Warnings and Precautions on the opposite page.**

In uncomplicated overweight.

Many patients, on the other hand, present with excess fat but no disease. While this condition is often termed uncomplicated obesity, complications of both a social and a psychologic nature may be distressingly real for the patients. In these cases, a short-term regimen of Tenuate can help reinforce your dietary counsel during the important early weeks of an indicated weight loss program.

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The anorectic effectiveness of diethylpropion hydrochloride is well documented. No less than 16 separate double-blind, placebo-controlled studies attest to its usefulness in daily practice.[1] And the unique chemistry of Tenuate provides "...anorectic potency with minimal overt central nervous system or cardiovascular stimulation."[2] Compared with the amphetamines, diethylpropion has minimal potential for abuse.

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For prescribing information see opposite page

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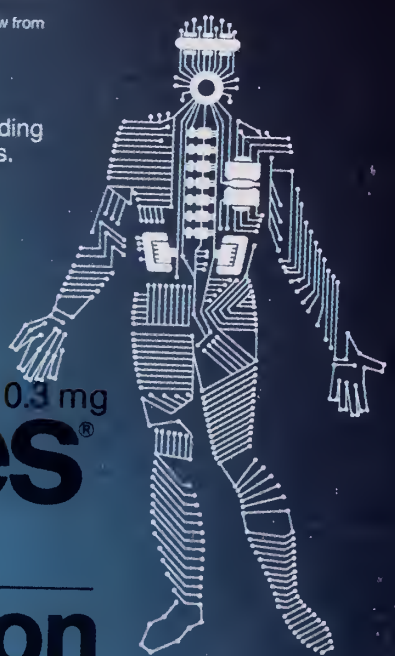
The drug's effectiveness in a given patient, its side effects, warnings, precautions, tolerance, etc. A rational therapeutic choice depends on a careful assessment of all such factors.

*Central alpha-adrenergic stimulation decreases sympathetic outflow from the brain, as shown in animal studies.

1 Data on file at Boehringer Ingelheim Ltd.

Please see last page for brief summary, including warnings, precautions, and adverse reactions.

Now available in new 0.3 mg tablets

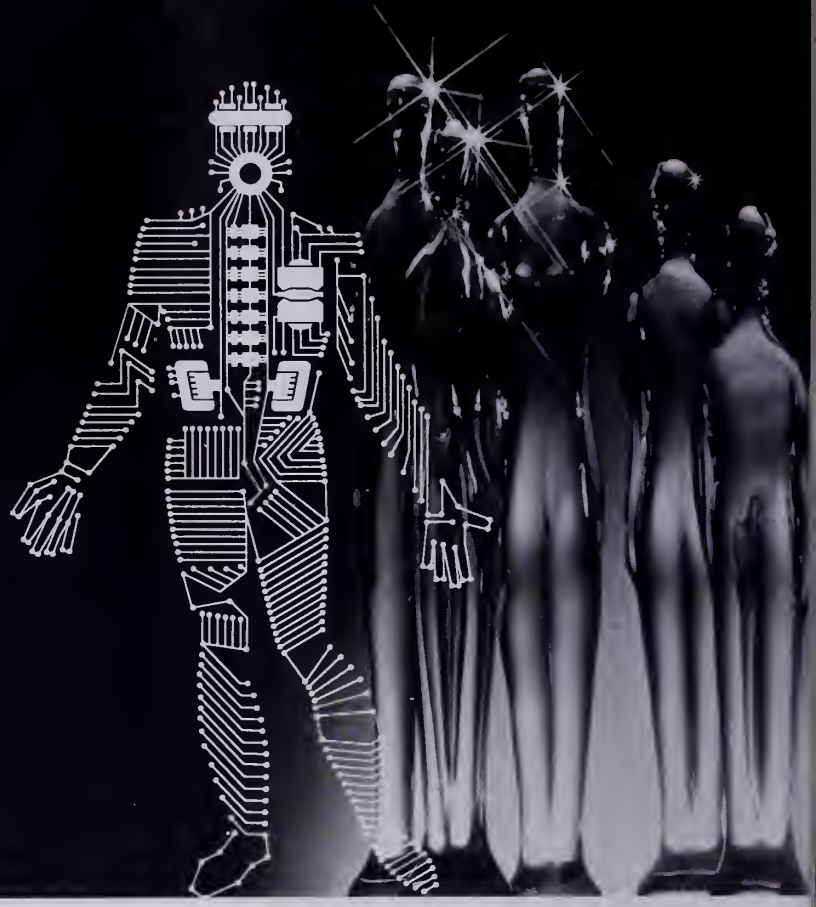


Tablets of 0.1, 0.2, 0.3 mg

Catapres®
(clonidine HCl)
Hypertension

The Alpha Advantage:

It's for all kinds of hypertensives



Tablets of 0.1, 0.2, 0.3 mg

Catapres®

(clonidine HCl)

Hypertension

- No contraindications.
- Effective in all degrees of hypertension. It is mild to moderate in potency.
- Low incidence of depression, impotence, orthostatic hypotension—no fatal hepatotoxicity.
- Preserves kidney blood flow.

Most common side effects are dry mouth, drowsiness, and sedation which generally tend to diminish with time.

The usual starting dose of Catapres is 0.1 mg at brea fast and 0.1 mg at bedtime. Some patients may bene from a starting dose of 0.1 mg at bedtime.

Usual daily dose range—0.2—0.8 mg

Maximum daily dose—2.4 mg
Doses as high as this have rarely been employed.

For optimal results, the dose of Catapres must be adjusted according to the patient's individual blood pressure response.

Catapres®
(clonidine hydrochloride)
Tablets of 0.1, 0.2, 0.3 mg

Indication: The drug is indicated in the treatment of hypertension. As an antihypertensive drug, Catapres (clonidine hydrochloride) is mild to moderate in potency. It may be employed in a general treatment program with a diuretic and/or other antihypertensive agents as needed for proper patient response.

Warnings: Tolerance may develop in some patients necessitating a reevaluation of therapy.
Usage in Pregnancy: In view of embryotoxic findings in animals, and since information on possible adverse effects in pregnant women is limited to uncontrolled clinical data, the drug is not recommended in women who are or may become pregnant unless the potential benefits outweigh the potential risk to mother and fetus.
Usage in Children: No clinical experience is available with the use of Catapres (clonidine hydrochloride) in children.

Precautions: When discontinuing Catapres (clonidine hydrochloride), reduce the dose gradually over 2 to 4 days to avoid a possible rapid rise in blood pressure and associated subjective symptoms such as nervousness, agitation, and headache. Patients should be instructed not to discontinue therapy without consulting their physician. Rare instances of hypertensive encephalopathy and death have been recorded after cessation of clonidine hydrochloride therapy. A causal relationship has not been established in these cases. It has been demonstrated that an excessive rise in blood pressure, should it occur, can be reversed by resumption of clonidine hydrochloride therapy or by intravenous phentolamine. Patients who engage in potentially hazardous activities, such as operating machinery or driving, should be advised of the sedative effect. This drug may enhance the CNS-depressive effects of alcohol, barbiturates and other sedatives. Like any other agent lowering blood pressure, clonidine hydrochloride should be used with caution in patients with severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

As an integral part of their overall long-term care, patients treated with Catapres (clonidine hydrochloride) should receive periodic eye examinations. While, except for some dryness of the eyes, no drug-related abnormal ophthalmologic findings have been recorded with Catapres (clonidine hydrochloride), in several studies the drug produced a dose-dependent increase in the incidence and severity of spontaneously occurring retinal degeneration in albino rats treated for 6 mo longer.

Adverse Reactions: The most common reactions are dry mouth, drowsine sedation. Constipation, dizziness, headache, and fatigue have been re Generally these effects tend to diminish with continued therapy. The fo reactions have been associated with the drug, some of them rarely. (Ir instances an exact causal relationship has not been established.) These i Anorexia, malaise, nausea, vomiting, parotid pain, mild transient abnorma liver function tests; one report of possible drug-induced hepatitis without and hyperbilirubinemia in a patient receiving clonidine hydrochloride, thalidone and papaverine hydrochloride. Weight gain, transient elevation c glucose, or serum creatine phosphokinase: congestive heart failure, Ray phenomenon; vivid dreams or nightmares, insomnia, other behavioral ch nervousness, restlessness, anxiety and mental depression. Also ra gioneurotic edema, hives, urticaria, thinning of the hair, pruritus not ass with a rash, impotence, urinary retention, increased sensitivity to alcohol, d itching or burning of the eyes, dryness of the nasal mucosa, pallor, gyneco weakly positive Coombs' test, asymptomatic electrocardiographic abnor manifested as Wenckebach period or ventricular trigeminy.

Overdosage: Profound hypotension, weakness, somnolence, diminished sent reflexes and vomiting followed the accidental ingestion of Catapres (cl hydrochloride) by several children from 19 months to 5 years of age. lavage and administration of an analeptic and vasopressor led to comp covery within 24 hours. Tolazoline in intravenous doses of 10 mg at 30 intervals usually abolishes all effects of Catapres, (clonidine hydrochlorid dosage.

How Supplied: Catapres, brand of clonidine hydrochloride, is available as (tan) and 0.2 mg (orange) oval, single-scored tablets in bottles of 100 and 10 available as 0.3 mg (peach) oval, single-scored tablets in bottles of 100.

For complete details, please see full prescribing information.
Under license from Boehringer Ingelheim GmbH

Boehringer Ingelheim
Boehringer Ingelheim
Ridgefield, CT 06877

Pioneers in Medicine For the Family

BOOTS PHARMACEUTICALS, INC.

Operating in the U.S. since 1977, Boots is a world-wide leader in pharmaceutical research and manufacture. Boots has directed its efforts toward providing products useful in the practice of family medicine.

Some of our better known products are Ru-Tuss® and Ru-Vert® . This advertisement highlights three other products particularly useful for the family.

F-E-P CREME® **TWIN-K®** **SU-TON®**





For the Majority of Steroid-Responsive Dermatoses* Seen in Family Practice

F-E-P CREME®

(Iodochlorhydroxyquin – Pramoxine HCl – Hydrocortisone)

The 4 in 1 Corticosteroid Cream

Anti-inflammatory, antifungal, antibacterial actions, and, uniquely, a topical anesthetic for immediate relief of the itching or burning that frequently accompanies skin problems. One size (1/2 ounce), one strength for ease of prescription.

*This drug has been evaluated as possibly effective for these indications. See prescribing information on last page of this advertisement.

For Potassium Supplementation

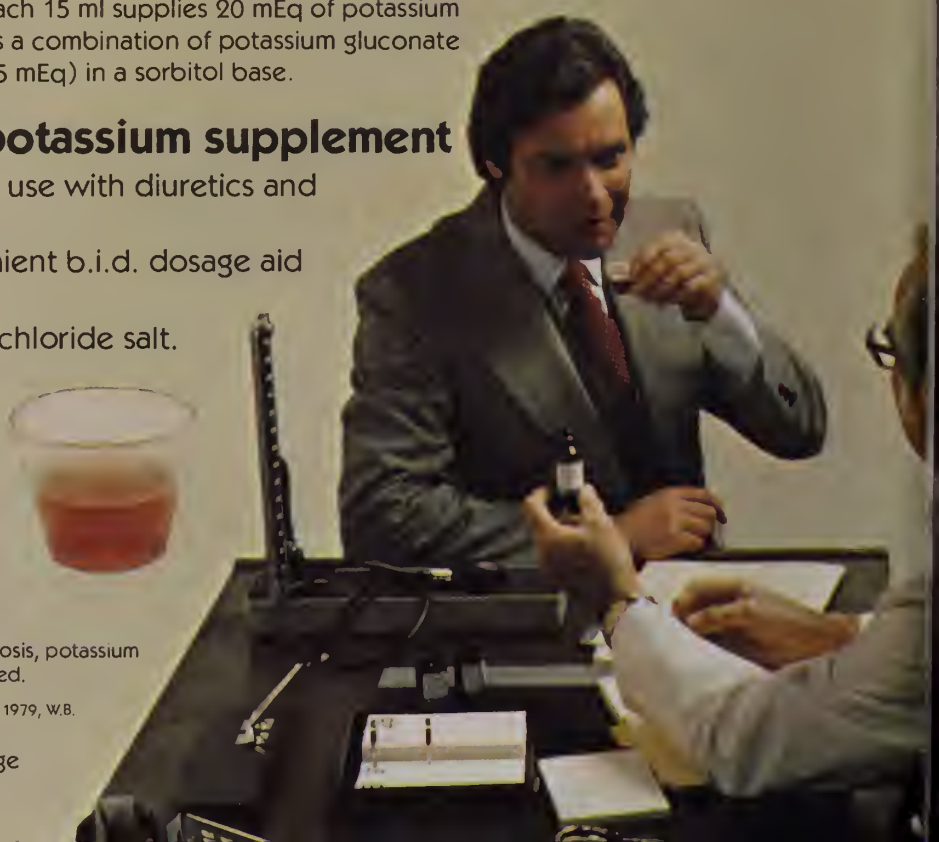
TWIN-K®

Each 15 ml supplies 20 mEq of potassium as a combination of potassium gluconate (15 mEq) and potassium citrate (5 mEq) in a sorbitol base.

The good tasting potassium supplement

- Designed for prophylactic use with diuretics and adrenocorticoids.
- Pleasant taste and convenient b.i.d. dosage aid patient compliance.
- Avoids the problems of a chloride salt.

"The organic salt can be given as a liquid without producing significant gastric symptoms and without an untoward effect on the mucosa of the small intestine."[1]



Note: In hypokalemic hypochloremic alkalosis, potassium chloride supplementation may be preferred.

1. Beeson-McDermott, Textbook of Medicine, 15th Ed. 1979, W.B. Saunders Co., Philadelphia, p. 1959

See prescribing information on last page of this advertisement.

For the Geriatric Patient

SU-TON®

Liquid Tonic

A pleasant tasting prescription tonic containing iron, vitamins, minerals, an analeptic and 18% alcohol. Ideal for those who may benefit from vitamin deficiency prevention. Just one tablespoon before each meal.

Each 45 ml (3 tablespoonfuls) contains:

Pentylenetetrazol	30 mg
Niacin	50 mg
Vitamin B-1	10 mg
Vitamin B-2	5 mg
Vitamin B-6	1 mg
Vitamin B-12	3 mcg
Choline	100 mg
Inositol	50 mg
Manganese (as Manganese Sulfate)	1 mg
Magnesium (as Magnesium Sulfate)	2 mg
Zinc (as Zinc Sulfate)	1 mg
Iron (as Ferric Pyrophosphate, Soluble)	22 mg
Alcohol	18%

ee prescribing information on last page of this advertisement.



Please send me patient starter samples of:

☐ **F-E-P CREME®**

☐ **TWIN-K®**

☐ **SU-TON®**

Name _____

Street Address _____

City _____ State _____ Zip _____

F-E-P CREME®

DESCRIPTION: F-E-P Creme is a topical water soluble anti-inflammatory, anesthetic, preparation intended for treatment of various inflammatory skin disorders. The drug contains the following active ingredients:

Iodochlorhydroxyquin	3.0%
Pramoxine Hydrochloride	0.5%
Hydrocortisone	1.0%

INDICATIONS AND USAGE:

Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, FDA has classified the indications as follows, "Possibly effective": Contact or atopic dermatitis; impetiginized eczema; nummular eczema; infantile eczema; endogenous chronic infectious dermatitis; stasis dermatitis; pyoderma; nuchal eczema and chronic eczematoid otitis externa; acne urticata; localized or disseminated neurodermatitis; lichen simplex chronicus; anogenital pruritus (vulvae, scroti, ani), folliculitis; bacterial dermatoses; mycotic dermatoses such as tinea (capitis, cruris, corporis, pedis); moniliasis; intertrigo. Final classification on the less-than-effective indications requires further investigation.

Pramoxine Hydrochloride promptly relieves pain and itch. This compound may be used safely on the skin of those patients sensitive to the "caine" type local anesthetics.

CONTRAINDICATIONS: Hypersensitivity to F-E-P Creme, or any of its ingredients or related compounds; lesions of the eye; tuberculosis of the skin; most viral skin lesions (including herpes simplex, vaccinia and varicella).

WARNINGS: This product is not for ophthalmic use. In the presence of systemic infections, appropriate antibiotics should be used.

USE IN PREGNANCY: Topical steroids have not been reported to have an adverse effect on pregnancy. However, fetal abnormalities have been produced in pregnant laboatory animals that have been exposed to large doses of topical corticosteroids. Drugs of this class should not be used extensively during pregnancy.

PRECAUTIONS: F-E-P Creme may be irritating to the skin in some patients. If irritation occurs discontinue therapy. Staining of clothes or hair may also occur with use of this preparation. Although systemic toxicity has not been reported with this drug, adrenal pituitary suppression is possible, especially when the drug is used extensively or kept under an occlusive dressing for a prolonged period. Iodochlorhydroxyquin can be absorbed through the skin and interfere with thyroid function tests. Therapy with this preparation should stop at least a month before performance of these tests.

The ferric chloride test for phenylketonuria (PKU) can be positive if F-E-P Creme is on the diaper or in the urine. Prolonged use of this drug may result in an overgrowth of nonsusceptible organisms requiring appropriate therapy.

ADVERSE REACTIONS: Skin rash or hypersensitivity may occur following topical application. The following local adverse reactions have been reported with topical corticosteroids, especially under occlusive dressings: burning, itching, irritation, dryness, folliculitis, hypertrichosis, acneiform eruptions, hypopigmentation, perioral dermatitis, allergic contact dermatitis, maceration of the skin, secondary infection, skin atrophy, striae, miliara. Discontinue therapy if untoward reactions occur.

DOSAGE AND ADMINISTRATION: Apply a thin layer of the drug to affected parts 3-4 times daily.

Note:

1. **F-E-P Creme** is distributed with 3.0% iodochlorhydroxyquin for use when antibacterial/antifungal activity is desired.
2. **F-E-P Creme (Plain)** is the regular formulation, but without iodochlorhydroxyquin.

Both of these preparations contain pramoxine hydrochloride, which has topical anesthetic properties. Pramoxine is not chemically related to benzoic acid or amide type topical anesthetics. Patients can tolerate pramoxine although they may be sensitive to other "caine" type of topical or local anesthetics.

HOW SUPPLIED:

F-E-P Creme	F-E-P Creme Plain
½ ounce (15 gm) tubes	½ ounce (15 gm) tubes
NDC 0524-0026-51	NDC 0524-0025-51

CAUTION: Federal law prohibits dispensing without a prescription.

TWIN-K®

DESCRIPTION: Each 15 milliliter (tablespoonful) supplies 20 mEq of elemental potassium as a combination of potassium gluconate (15 mEq) and potassium citrate (5 mEq) in a sorbitol base with flavoring.

INDICATIONS AND USAGE: For use as oral potassium therapy in the prevention or treatment of hypokalemia which may occur secondary to diuretic or corticosteroid administration. It may be used in the treatment of cardiac arrhythmias due to digitalis intoxication.

CONTRAINDICATIONS: Severe renal impairment with oliguria or azotemia, untreated Addison's disease, adynamia episodica hereditaria, acute dehydration, heat cramps and hyperkalemia from any cause. This product should not be used in patients receiving aldosterone antagonists or triamterene.

WARNINGS: TWIN-K (potassium gluconate and potassium citrate) is a palatable form of oral potassium replacement. It appears that little if any potassium gluconate-citrate penetrates as far as the jejunum or ileum where enteric coated potassium chloride lesions have been noted. Excessive, undiluted doses of TWIN-K may cause a saline laxative effect.

To minimize gastrointestinal irritation it is recommended that TWIN-K be taken with meals or diluted with water or fruit juice. A tablespoonful (15 ml) in 8 ounces of water is approximately isotonic. More than a single tablespoonful should not be taken without prior dilution.

PRECAUTIONS: Potassium is a major intracellular cation which plays a significant role in body physiology. The serum level of potassium is normally 3.8–5.0 mEq/liter. While the serum or plasma level is a poor indicator of total body stores, a plasma or serum level below 3.5 mEq/liter is considered to be indicative of hypokalemia.

The most common cause of hypokalemia is excessive loss of potassium in the urine. However, hypokalemia can also occur with vomiting, gastric drainage and diarrhea.

Usually a potassium deficiency can be corrected by oral administration of potassium supplements. With normal kidney function it is difficult to produce potassium intoxication by oral administration. However, potassium supplements must be administered with caution since usually the exact amount of the deficiency is not accurately known. Checks on the patient's clinical status and periodic E.K.G. and/or serum potassium levels should be made. High serum potassium levels may cause death by cardiac depression, arrhythmias or arrest.

In patients with hypokalemia who also have alkalosis and a chloride deficiency (hypokalemic hypochloremic alkalosis), there will be a requirement for chloride ions. TWIN-K is not recommended for use in these patients.

ADVERSE REACTIONS: Symptoms of potassium intoxication include paresthesias of the extremities, flacid paralysis, listlessness, mental confusion, weakness and heaviness of the legs, fall in blood pressure, cardiac arrhythmias and heart block. Hyperkalemia may exhibit the following electrocardiographic abnormalities: disappearance of the P wave, widening and slurring of the QRS complex, changes of the ST segment and tall peaked T waves.

TWIN-K taken on an empty stomach in undiluted doses larger than 30 ml can produce gastric irritation with nausea, vomiting, diarrhea, and abdominal discomfort.

OVERDOSAGE: The administration of oral potassium supplements to persons with normal kidney function rarely causes serious hyperkalemia. However, if the renal excretory function is impaired potentially fatal hyperkalemia can result. It is important to note that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration with E.K.G. changes.

Treatment measures include:

1. Elimination of potassium containing drugs or foods.
2. Intravenous administration of 300 to 500 ml/hr of a 10% dextrose solution containing 10–20 units of crystalline insulin per 1000 milliliters.
3. Correction of acidosis.
4. Use of exchange resins or peritoneal dialysis.

In treating hyperkalemia it should be noted that patients stabilized on digitalis can develop digitalis toxicity when the serum potassium concentration is changed too rapidly.

DOSAGE AND ADMINISTRATION: The usual adult dosage is one tablespoonful (15 ml) in 6-8 fluid ounces of water or fruit juice, two to four times a day. This will supply 40 to 80 mi elemental potassium. The usual preventative dose of potass 20 mEq per day while therapeutic doses range from 30 m 100 mEq per day. Because of the potential for gastrointe irritation, undiluted large single doses (30 ml or more) or T are to be avoided.

Deviations from this schedule may be indicated, since no av total daily dose can be defined, but must be governed by observation for clinical effects.

HOW SUPPLIED: Pint bottles. NDC 0524-0021-16

CAUTION: Federal law prohibits dispensing without a pre tion.

SU-TON®

DESCRIPTION: Forty-five ml of SU-TON contains the follo ingredients:

Pentylenetetrazol	
Niacin	
Vitamin B-1	
Vitamin B-2	
Vitamin B-6	
Vitamin B-12	
Choline	1
Inositol	
Manganese (as Manganese Sulfate)	
Magnesium (as Magnesium Sulfate)	
Zinc (as Zinc Sulfate)	
Iron (as Ferric Pyrophosphate, Soluble)	
Alcohol	

INDICATIONS AND USAGE: SU-TON contains pentylenete which may be helpful in the older patient as an analeptic when mental confusion and memory defects are present. SU also contains vitamins, trace minerals, and iron, for those pe who may benefit by preventing the development of a defic

CONTRAINDICATIONS: Epilepsy, convulsive disorders or h history of sensitivity to any of the listed active ingredients.

WARNINGS: The safety of this preparation during pregnanc lactation has not been established. Use of this drug require the physician evaluate the potential benefits of the drug a any possible hazard to the mother and child.

PRECAUTIONS: Although there are no absolute contrai tions to pentylenetetrazol, it should be used with caut epileptic patients or those known to have a low con threshold or a focal brain lesion. Caution should be exe when treating patients with high doses of SU-TON who have disease. While pentylenetetrazol does not act directly c myocardium, the results from central vagal stimulation cause bradycardia.

ADVERSE REACTIONS: Pentylenetetrazol in high dose produce toxic symptoms typical of central nervous s stimulants, which act on the higher motor centers and the cord. Convulsions resulting from this drug are spontaneo are not induced by external stimuli. They usually last for s minutes and are followed by profound depressio respiratory paralysis. Death has been reported from the ing of 10 grams of pentylenetetrazol.

DRUG ABUSE: Drug dependence has not been reporte SU-TON.

OVERDOSAGE: Signs and symptoms of acute overdose n due principally from overstimulation of the central n system and from excessive vasodilatation with res autonomic nervous system imbalance. The symptoms may i the following: vomiting, agitation, tremors, hyperreflexia, ing, confusion, hallucinations, headache, hyperp tachycardia. Treatment consists of appropriate supp measures. If signs and symptoms are not too severe a patient is conscious, gastric evacuation may be accomplis induction of emesis or gastric lavage.

Intensive care must be provided to maintain adequate tion and respiratory exchange.

DOSAGE AND ADMINISTRATION: One tablespoonful (1 times a day 20-30 minutes before meals This drug is not fo children under 12 years of age.

HOW SUPPLIED:

8ottles of 473 ml (16 fl oz) NDC 0524-0

CAUTION: Federal law prohibits dispensing without a pi tion.

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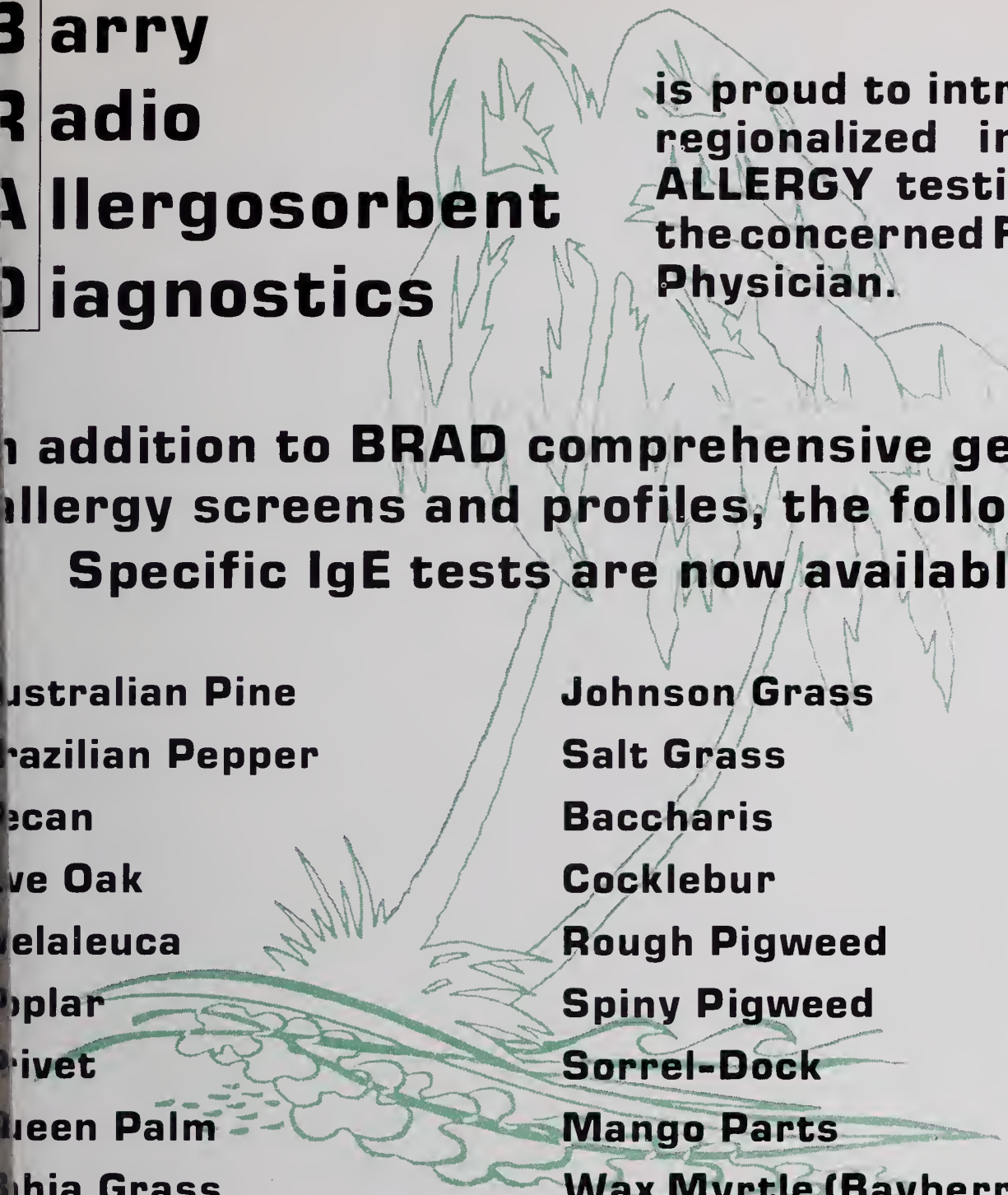
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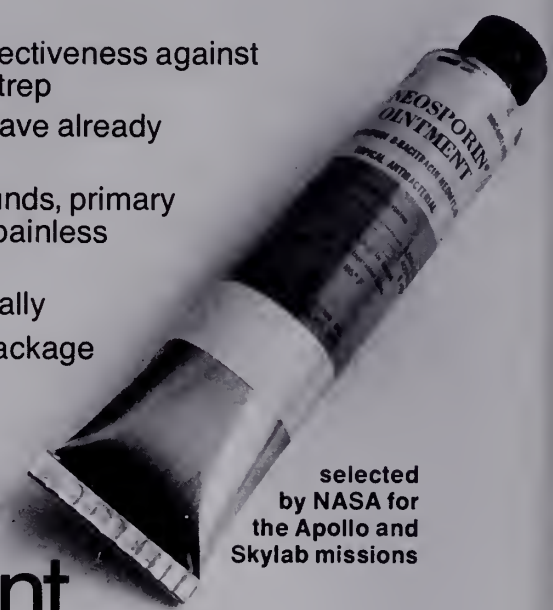
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1. provides broad-spectrum, overlapping antibacterial effectiveness against common susceptible pathogens, including staph and strep
2. helps prevent topical infections, and treats those that have already started
3. it's good medicine for abrasions, lacerations, open wounds, primary pyodermas, secondarily infected dermatoses; and it's painless and cosmetically pleasing
4. contains three antibiotics that are rarely used systemically
5. you can recommend it in any of the three convenient package sizes: 1 oz tube, ½ oz tube, or the versatile, single-use foil packet



selected by NASA for the Apollo and Skylab missions

NEOSPORIN® Ointment

(polymyxin B-bacitracin-neomycin)

Each gram contains: Aerosporin® (Polymyxin B Sulfate) 5,000 units, bacitracin zinc 400 units, neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

ONE HUNDRED YEARS WELLCOME

Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

Child Abuse and Neglect

Throughout the State during the past year, the Florida Medical Auxiliary Child Abuse and Neglect Program has made great strides in many different areas.

A brochure entitled "Beyond Education: Our Responsibility to Abused and Neglected Children," is designed to provide teacher information regarding this important issue. It was compiled and distributed by the FMAA to kindergarten through sixth grade teachers in the Florida public schools. During the coming year, the brochure will be distributed to grades seven through 12.

County auxiliaries have appointed committees to identify and investigate various needs in their communities. Projects developed to date include parenting and pre-parenting classes, task forces, Parents Anonymous, interaction with other social service groups, acting as Guardian Ad Litem (appointment of independent representation in child abuse proceedings so the best interest of the child is maintained), and the establishment of therapeutic homes for children.

Many Auxiliary members serve on task forces directly relating to issues of child abuse and neglect, finding themselves in an excellent position to serve in this capacity because of their involvement in both the professional and lay communities. The Lee County Auxiliary Child Trauma Team has played a significant role in coordinating the services of health agencies involved in child trauma. Individual auxiliary members in Pinellas County have joined the child abuse task force, sponsored by the Junior League of Clearwater, to establish a location for children whose families are experiencing stress. These members have become part of the public awareness subcommittee helping to educate the community and to procure support for the project.

Parenting and pre-parenting classes are an important educational tool for preventing child abuse and for establishing better family relationships. Many county auxiliary members are helping to develop and support these classes. In Polk County members have been actively working with the Winter Haven Community Health Center, the public schools and the hospitals to establish a Parenting Skills project.

Many members of the Palm Beach Medical Auxiliary and their husbands have been directly involved in opening THE HAVEN in Delray Beach. THE HAVEN is a residential home for dependent, neglected, non-delinquent boys. Future expansion includes the establishment of a girls' facility.

Indeed, Florida Medical Auxiliary involvement in child abuse and neglect programs has proven to have a "ripple" effect throughout the entire State.

Lo Ann Trask
Chairman, FMAA Child Abuse Committee



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That makes *us* happy.

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- Diabetes Mellitus
- Hemorrhagic Disorders
- Hepatitis
- Hypoxic States
- Lymphomas, Leukemias
- Malnutritional Anemias
- Portal Hypertension
- Renal Stones
- Renal Transplantation
- Solid Tumors
- Tuberculosis

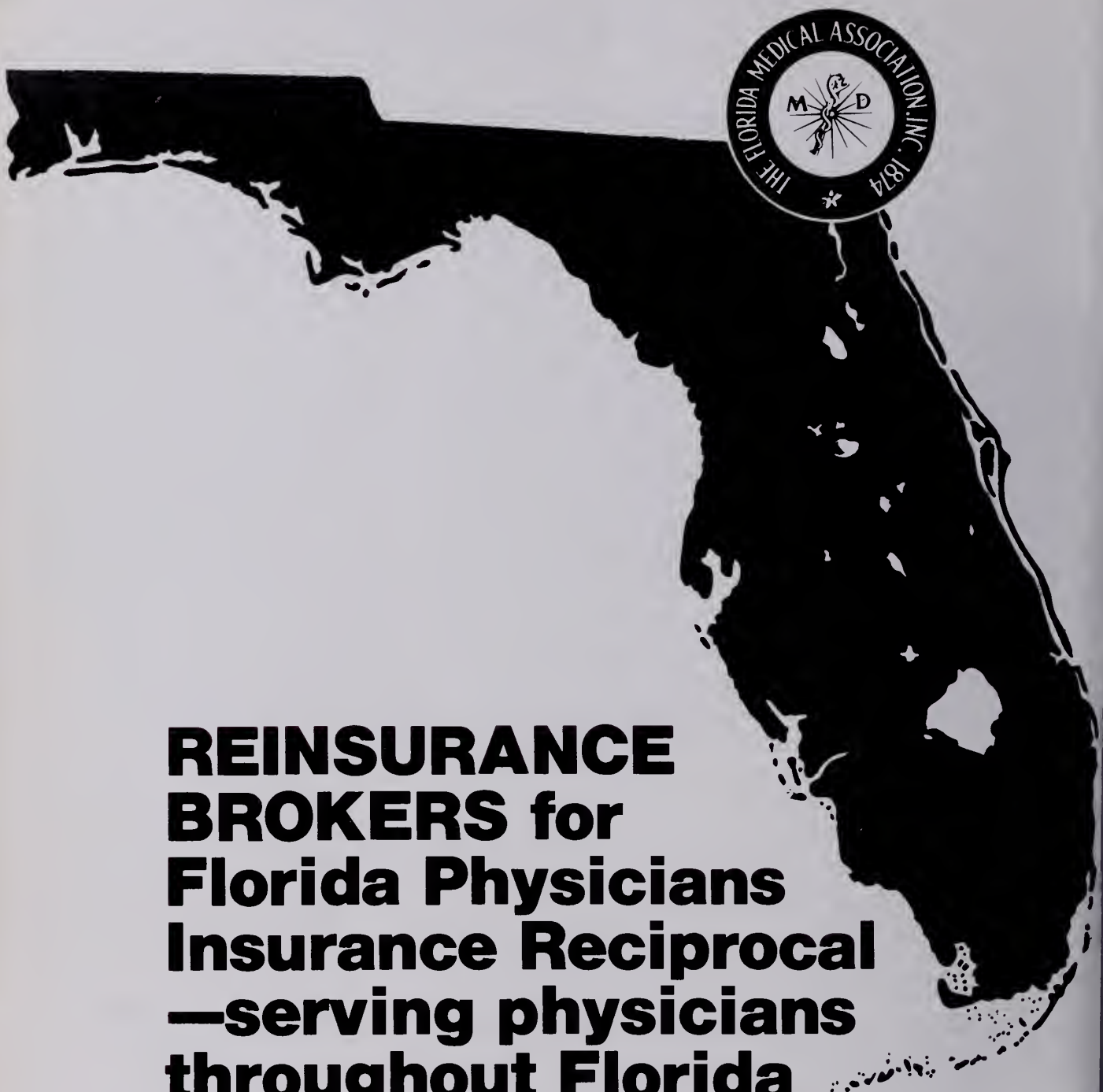
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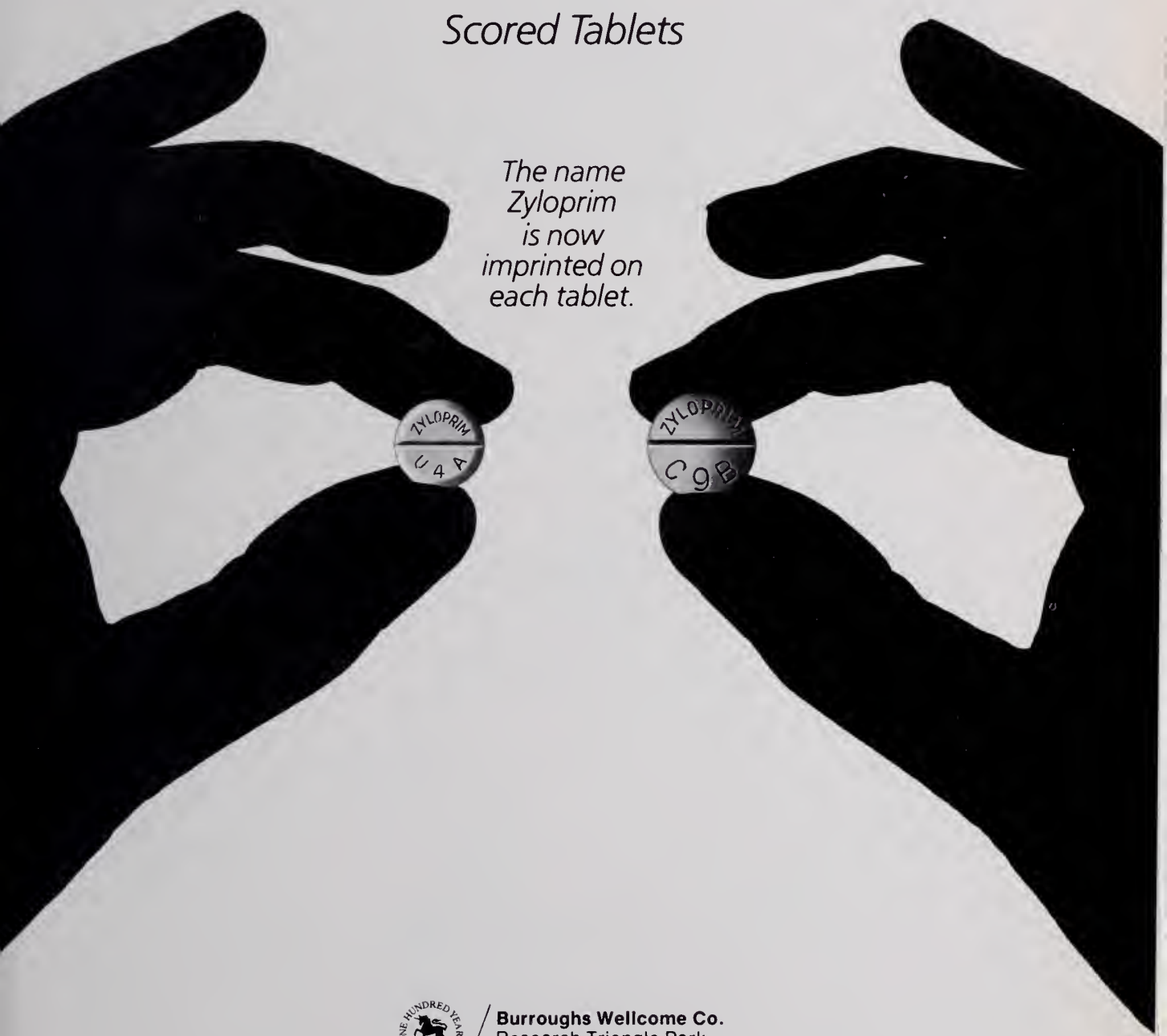
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Ingredients:
6-[2-Hydroxy-1-naphthyl)azo]-3,4'-azodibenzenesulfonic Acid (Biebrich Scarlet Red, Water Soluble) 0 1% in an ointment base containing Peruvian Balsam, Zinc Oxide, Starch, Castor Oil, Petrolatum, Sodium Propionate, Methlyparaben, Propylparaben, Propylene Glycol and Water.

Indications: As an aid in the management of decubitus ulcers.
Administration: Pour a small amount of 3% Hydrogen Peroxide or Normal Saline onto the affected area. Cleanse thoroughly and apply ointment. Cover with dry sterile gauze. Dressing should be changed twice **daily**.
Contraindications: Known hypersensitivity to any of the ingredients
Adverse Reactions: Gastroenteritis and renal irritation have been reported following percutaneous absorption over a massive area.
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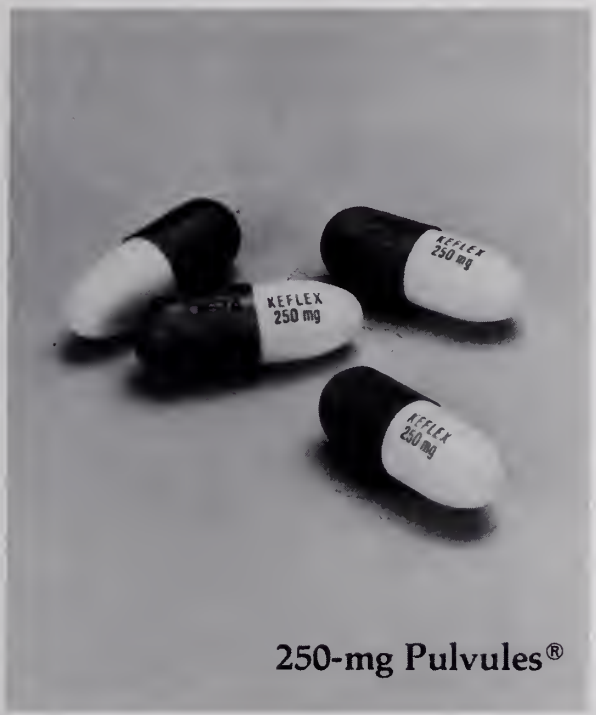


DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestetic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultent oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexuel development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejeculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblett, M.D., R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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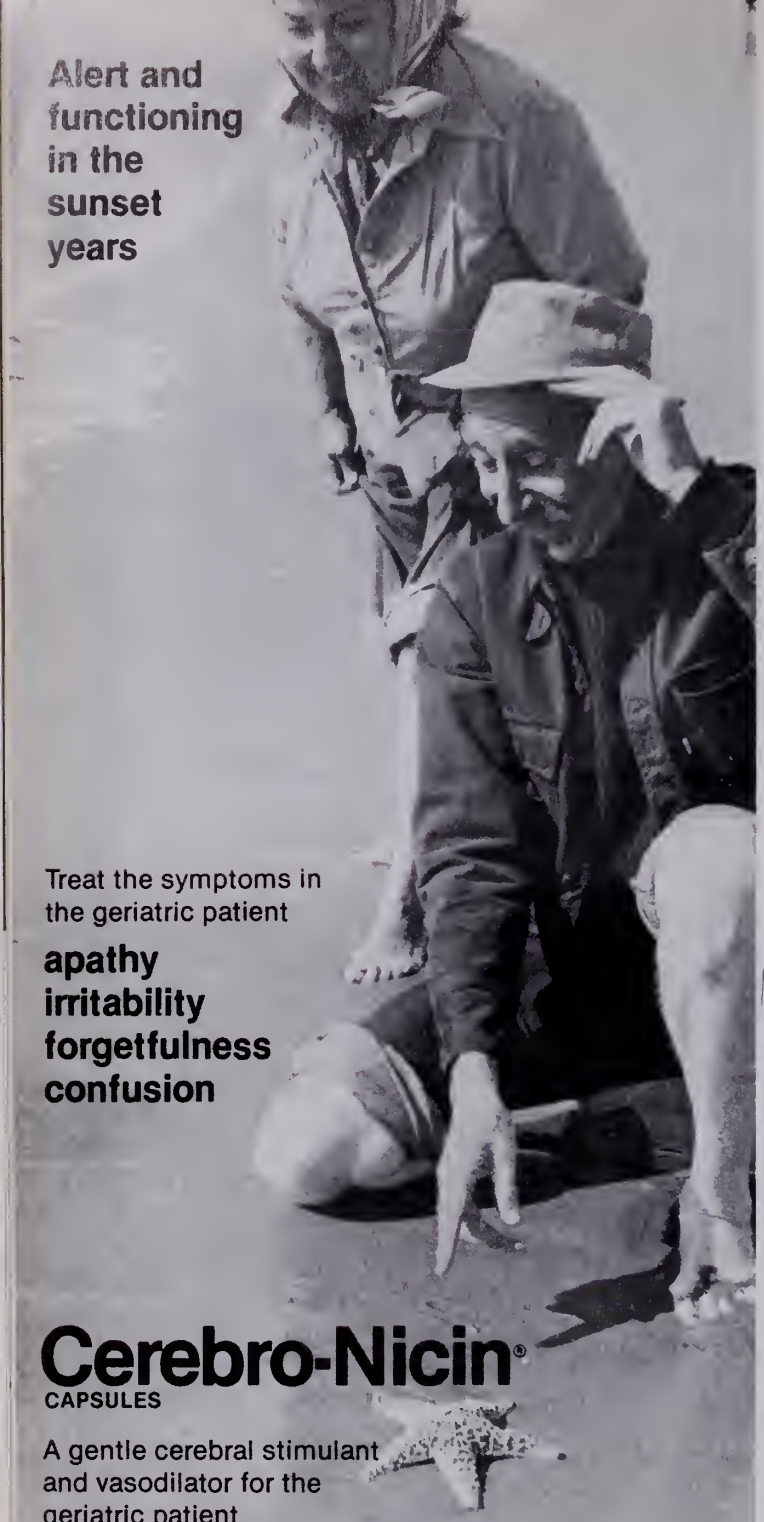
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CONTRAINDICATIONS: Epilepsy or low convulsive threshold.

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MEETINGS

Accepted by the FMA Committee on Continuing Medical Education for Mandatory Credit

NOVEMBER

Clinical Diabetes 1980, Nov. 1, Auditorium, University of South Florida College of Medicine, Tampa. For information: Brendan C. O'Malley, M.D., Box 45, 12901 N. 30th St., Tampa 33612.

Difficult Decisions in Cancer Management, Nov. 1, Holiday Inn, (Sarasota) Longboat Key. For information: S. P. Bralow, M.D., 1814 Hillview Street, Sarasota 33579.

Emergencies in Internal Medicine, Nov. 2-7, Sheraton Bal Harbour, Bal Harbour. For information: Division of CME, University of Miami School of Medicine, Box 016960, Miami 33101.

Fourth Annual Suncoast Perinatal Conference, Nov. 7-8, Bayfront Medical Center, St. Petersburg. For information: Mrs. Pat Fowler, Bayfront Medical Center, 701 Sixth St. S., St. Petersburg 33701.

III International Conference on the Theory of Positive Disintegration, Nov. 7-10, Jackson Memorial Hospital, Miami. For information: Division of CME, University of Miami School of Medicine, Box 016960, Miami 33101.

Vascular Lesion of CNS, Nov. 10, Citrus Memorial Hospital, Inverness. For information: R. Edward Dodge Jr., M.D., 511 W. Highland Blvd., Inverness 32650.

Sixth Annual Pan American Medical Seminar, (In Spanish), Nov. 10-14, Mount Sinai Medical Center, Miami Beach. For information: CME Office, Federico R. Justiniani, M.D., Mount Sinai Medical Center, 4300 Alton Road, Miami Beach 33140.

Hypertension Workshop, Nov. 13, Abbey Hospital Conference Room, Coral Gables. For information: Anthony J. Pellicane Sr., M.D., 5190 S.W. 8th St., Coral Gables 33134.

Clinical Management Testing of Coronary Disease and Exercise, Nov. 14-16, Orlando Hyatt, Kissimmee. For information: International Medical Education Corporation, Division of Postgraduate Education, Dept. 12, 64 Inverness Drive East, Englewood, Colorado 80112.

Hypertension Seminar, Nov. 15, Breckenridge Hotel, St. Petersburg Beach. For information: Walter Hamilton, M.D., 432 Pasadena Avenue, South, St. Petersburg 33707.

Brief and Emergency Psychotherapy, Nov. 15, Florida International University, Miami. For information: Adonna M. Rutland, MSN, ARNP, 19711 S.W. 113 Place, Miami 33176.

Pediatrics 1980, Nov. 15-16, American Hospital, Auditorium, Miami. For information: Ramon Rodriguez-Torres, M.D., 11880 Bird Road, Suite 416, Miami 33175.

Intensive Review Course in Family Medicine, Nov. 17-21, Airport Holiday Inn, Tampa. For information: Charles E. Aucremann, M.D., USF Medical Center, Dept. of Family Medicine, Box 13, 12901 N. 30th Street, Tampa 33612.

Being an Effective Clinical Teacher, Nov. 17-21; Feb. 2-6, 1981, Sheraton Bal Harbour, Bal Harbour; Keystone, Colorado (Feb.). For information: Division of CME (D23-3), University of Miami School of Medicine, P.O. Box 016960, Miami 33101.

12th Family Practice Review, Nov. 17-21, Gainesville Hilton, Gainesville. For information: Bill Rockwood, Box J-233, J.H.M. Health Center, Gainesville 32610.

Rhinoplasty — 1980, Nov. 9-13, Sonesta Beach Hotel, Key Biscayne. For information: Robert L. Simons, M.D., 16800 N.W. Second Avenue, North Miami Beach 33169.

DECEMBER

Basic Life Support (CPR), Dec. 2, University Community Hospital Conference Room, Tampa. For information: John E. Perchalski, M.D., 10320 North 56th Street, Suite G, Temple Terrace 33617.

Laparoscopy Techniques and Therapeutic Techniques, Dec. 3-5, Contemporary Resort Hotel, Walt Disney World, Lake Buena Vista. For information: H. Worth Boyce Jr., M.D., USF Medical Center, Box 19, 12901 North 30th Street, Tampa 33612.

The 6th Annual Course in Behavioral Neurology, Dec. 4-6, Daytona Hilton, Daytona Beach. For information: Edward Valenstein, M.D., Box J-236, J.H.M. Health Center, Gainesville 32610.

Hypertension Rounds, Dec. 10, The Deauville Hotel, Miami Beach. For information: Barry J. Materson, M.D., 1201 N.W. 16th Street, Miami 33125.

Seminars in Family Practice, Dec. 11-13, Sundial Resort, Sanibel Island. For information: Dennis D. Frink, D.O., 753 Pondella Road, North Ft. Myers 33903.

Neuro-Ophthalmology Course, Dec. 11-13, Key Biscayne Hotel, Key Biscayne. For information: Division of CME (D23-3), University of Miami School of Medicine, P.O. Box 016960, Miami 33101.

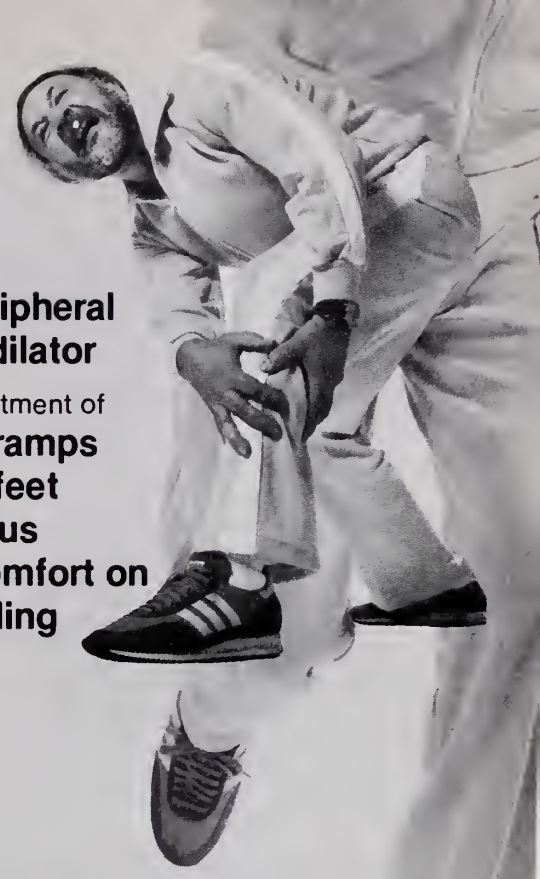
Rehabilitation of Limb Function in Paralytic Disorders, Dec. 11-13, Sheraton Bal Harbour, Bal Harbour. For information: Division of CME (D23-3), University of Miami School of Medicine, P.O. Box 016960, Miami 33101.

JANUARY

25th Annual Cardiovascular Seminar, Jan. 9-10. Sarasota-Longboat Key Holiday Inn, Longboat Key. For information: Mr. E. Jerry Eatman, Executive Director, American Heart Association, Suncoast Chapter, Inc., Box 12407, St. Petersburg 33733.

IV Annual Review in Oral Pathology, Jan. 12-16, UM/Jackson Memorial Hospital/Mailman Center. For information: Division of CME, University of Miami School of Medicine, Box 016960, Miami 33101.

Neurological Update 1981, Jan. 14-18, Eden Roc Hotel, Miami Beach. For information: Division of CME, University of Miami School of Medicine, Box 016960, Miami 33101.



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REF PI

3rd Annual Walt Disney World Pulmonary Wintercourse, Jan. 15-18, Dutch Inn Resort Hotel, Walt Disney World, Lake Buena Vista. For information: Asher Marks, M.D., P.O. Box 8127, Jacksonville 32211.

16th Annual Pediatric Postgraduate Course, "Continuing Education in Pediatrics — 1981", Diplomat Resorts, Hollywood Beach. For information: Dr. Donald H. Altman, Pediatric Postgraduate Course, Variety Children's Hospital, 6125 S.W. 31st, Miami 33155.

13th Annual Postgraduate Seminar in Pediatric and Adult Urology, Jan. 21-24, Konover Hotel, Miami Beach. For information: Victor Politano, M.D., 6614 Miami Lakes Drive, East, Miami Lakes 33014.

8th Annual Symposium in Pediatric Nephrology: Current Concepts in Diagnosis and Management, Jan. 25-29, Sheraton-Bal Harbour, Bal Harbour. For information: Jose Strauss, M.D., Division of Pediatric Nephrology (R-131), Box 016960, Miami 33101.

19th Annual Seminar "Imageology 1981", Jan. 25-30, Sheraton Bal Harbour, Miami Beach. For information: Lucy R. Kelley, c/o Miami Seminars, Box 343762, Coral Gables 33134.

2nd Annual Seminar "Practical Approaches to Diagnostic Problems in Radiology", Jan. 30-Feb. 2, Dutch Inn, Lake Buena Vista. For information: Lucy R. Kelley, c/o Miami Seminars, Box 343762, Coral Gables 33134.

Florida Society of Pathologists Annual Slide Seminar, Jan. 31-Feb. 1, Contemporary Building (Disney World), Lake Buena Vista. For information: C. F. McConnell, M.D., 5151 N. Ninth Ave., Pensacola 32504.

FEBRUARY

6th Annual Review and Recent Practical Advances in Pathology, Feb. 1-6, Sheraton Bal Harbour, Bal Harbour. For information: Division of CME, University of Miami School of Medicine, Box 016960, Miami 33101.

Florida Mid-Winter Seminar in Ophthalmology, Feb. 2-5, Doral Beach Hotel, Miami Beach. For information: Division of CME, University of Miami School of Medicine, Box 016960, Miami 33101.

Florida Mid-Winter Seminar in Otolaryngology, Feb. 6-8, Doral Beach Hotel, Miami Beach. For information: Division of CME, University of Miami School of Medicine, Box 016960, Miami 33101.

John T. Dickinson Annual Symposium: Advanced Facial Plastic and Reconstructive Surgery, Feb. 6-8, Holiday Inn Oceanside, Vero Beach. For information: Facial Surgery Symposium, Ferdinard F. Becker, M.D., 777 37th Street, Suite C-101, Vero Beach 32960.

1981 Update in OB/GYN, Feb. 9-11, Disney World, Lake Buena Vista. For information: Frank Riggall, M.D., Department of OB/GYN, Box J-294, University of Florida College of Medicine, Gainesville 32610.

Conference on the Beach, 2nd Annual Family Practice Update, Feb. 16-21, Daytona Hilton, Daytona Beach. For information: Richard W. Dodd, M.D., Halifax Hospital Medical Center, Box 1990 Daytona Beach 32015.

Florida Symposium on Micronutrients in Human Nutrition, Feb. 17-18, University of Florida, Gainesville. For information: James R. Kirk, Chairman, Food Science and Human Nutrition Department, University of Florida, Gainesville 32611.

Stress and Chemical Dependency — Strategies for the 80's, Feb. 19-22, The Breakers, Palm Beach. For information: Jose Almeida, M.D., Medical Director, Daryl Kosloske, Executive Director, 1014 N. Olive Avenue, West Palm Beach 33401.

Teaching Conference in Clinical Cardiology, Feb. 25-28, Sheraton Bal Harbour, Bal Harbour. For information: Division of CME, University of Miami School of Medicine, Box 016960, Miami 33101.

Internal Medicine 1981 (16th Annual Postgraduate Course), Feb. 28-Mar. 6, Sheraton Bal Harbour, Bal Harbour. For information: Division of CME, University of Miami School of Medicine, Box 016960, Miami 33101.

MARCH

Being an Effective Clinical Teacher, Mar. 2-6, Sheraton Bal Harbour, Bal Harbour. For information: Division of CME, University of Miami School of Medicine, Box 016960, Miami 33101.

Comprehensive Review in Basic Neurology for Psychiatrists and Generalists, Mar. 2-6, Konover Hotel, Miami Beach. For information: Division of CME, University of Miami School of Medicine, Box 016960, Miami 33101.

Problems in Rheumatology, Mar. 11-14, Don CeSar Beach Resort Hotel, St. Petersburg Beach. For information: Bernard F. Germain, M.D., Assistant Professor of Medicine, Director, Division of Rheumatology, Box 19, University of South Florida College of Medicine, 12901 North 30th Street, Tampa 33612.

Orthopaedics for Family and Emergency Physicians, Mar. 18-21, Royal Plaza Hotel, Lake Buena Vista. For information: Allan W. March, M.D., Box J-222, JHM Health Center, Gainesville 32610.

Pediatric Orthopedics for Family Practitioners and Pediatricians, Mar. 22-25, Sheraton Bal Harbour, Bal Harbour. For information: Division of CME, University of Miami School of Medicine, Box 016960, Miami 33101.

Current Clinical Concepts in Otolaryngology (in English and Spanish), Mar. 23-25, Eden Roc Hotel, Miami. For information: Division of CME, University of Miami School of Medicine, Box 016960, Miami 33101.

12th Annual Topics in Internal Medicine, Mar. 26-28, Gainesville Hilton, Gainesville. For information: Bill Rockwood, Box J-233, J.H.M. Health Center, Gainesville 32610.

Pan American Symposium on Trauma of Head and Neck (in English and Spanish), Mar. 26-28, Eden Roc Hotel, Miami Beach. For information: Division of CME, University of Miami School of Medicine, Box 016960, Miami 33101.

APRIL

Comprehensive Review Course: ECFMG, VQE, and FLEX (in Spanish), Apr. 6-July 17, UM/Jackson Memorial Hospital, Miami. For information: Division of CME, University of Miami School of Medicine, Box 016960, Miami 33101.

Atrial and Ventricular Arrhythmia Management Update, Apr. 16-18, Belleview Biltmore, Clearwater. For information: Bill Rockwood, Box J-233, J.H.M. Health Center, Gainesville 32610.

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PRIMARY CARE and subspecialty physicians to join multispecialty group in South Palm Beach County. Excellent facilities. Compensation includes possibility of ownership in P.A. Send CV to Post Office Box 23606, Oakland Park, Florida 33334.

INTERNIST: Wanted for association with six internists. Southeast coast of Florida. Board qualified; Florida Boards not necessary. Salary plus a percentage. Early partnership assured. Reply C-997, Post Office Box 2411, Jacksonville, Florida 32203.

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NEUROLOGIST: Opening for Neurologist in rapidly growing waterfront retirement community on Southwest coast of Florida. Send C.V. to C-996, Post Office Box 2411, Jacksonville, Florida 32203.

NEUROPATHOLOGIST — The Department of Pathology is seeking an Assistant Professor, a graduate of an AMA approved program in neuropathology to aid the Chief of the Division of Neuropathology. The individual should have a demonstrated interest and competence in diagnostic neuropathology, teaching, and clinical or laboratory investigation. He or she will work closely with the professional staffs of Pathology, Neurology, and Neurosurgery. The position is a full-time, tenure accruing medical school faculty appointment available 1 July 1981. Salary negotiable. Application deadline: 1 November 1980. Reply to: Raymond L. Hackett, M.D., Associate Chairman, Department of Pathology, Box J-275, College of Medicine, University of Florida, Gainesville, Florida 32610. An Equal Opportunity/Affirmative Action Employer.

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LOCUM TENENS work wanted — Family and General Practice, open availability. T. C. Kolff, M.D. (801) 566-1666.

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BOARD CERTIFIED PEDIATRICIAN wants partnership or solo, preferably small or rural area close to medical center. Phone (904) 795-9598 after 6 p.m. Luis S. Cortes, M.D., 30 Kingsbay Drive S.E., 103 A, Crystal River, Florida 32629.

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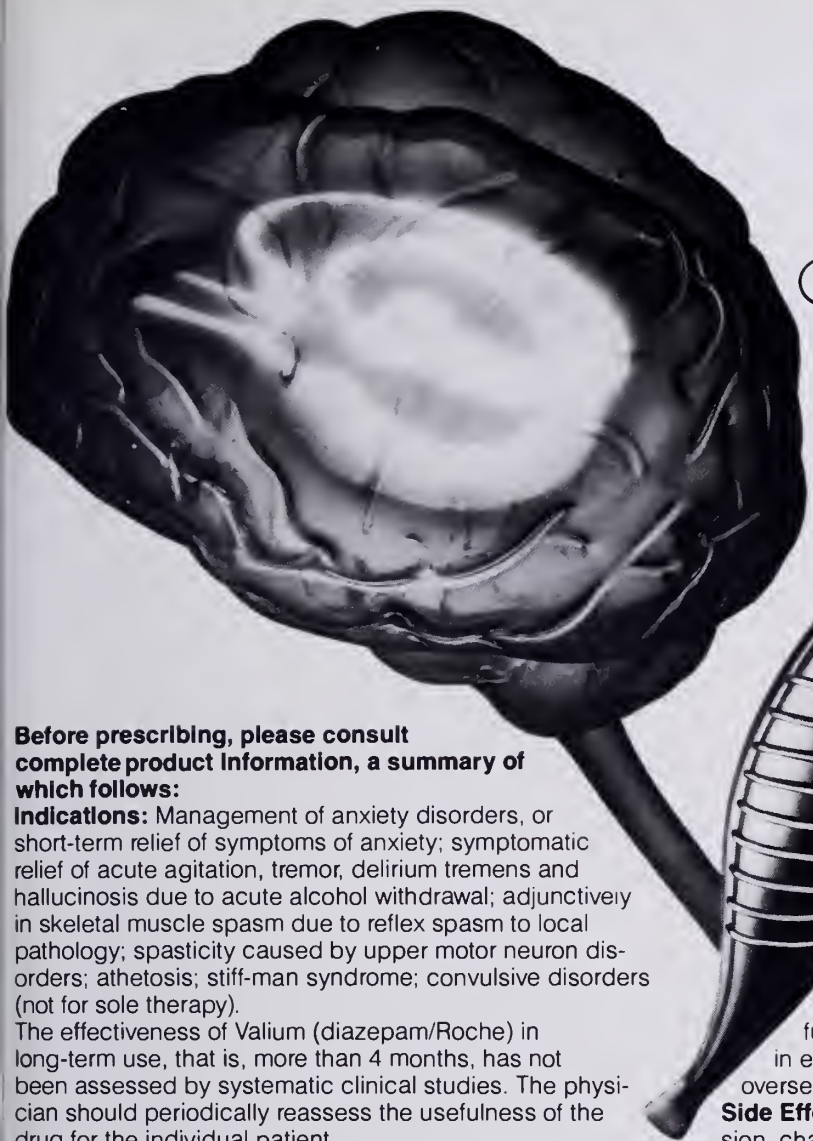
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The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Anxiety disorders, symptoms of anxiety, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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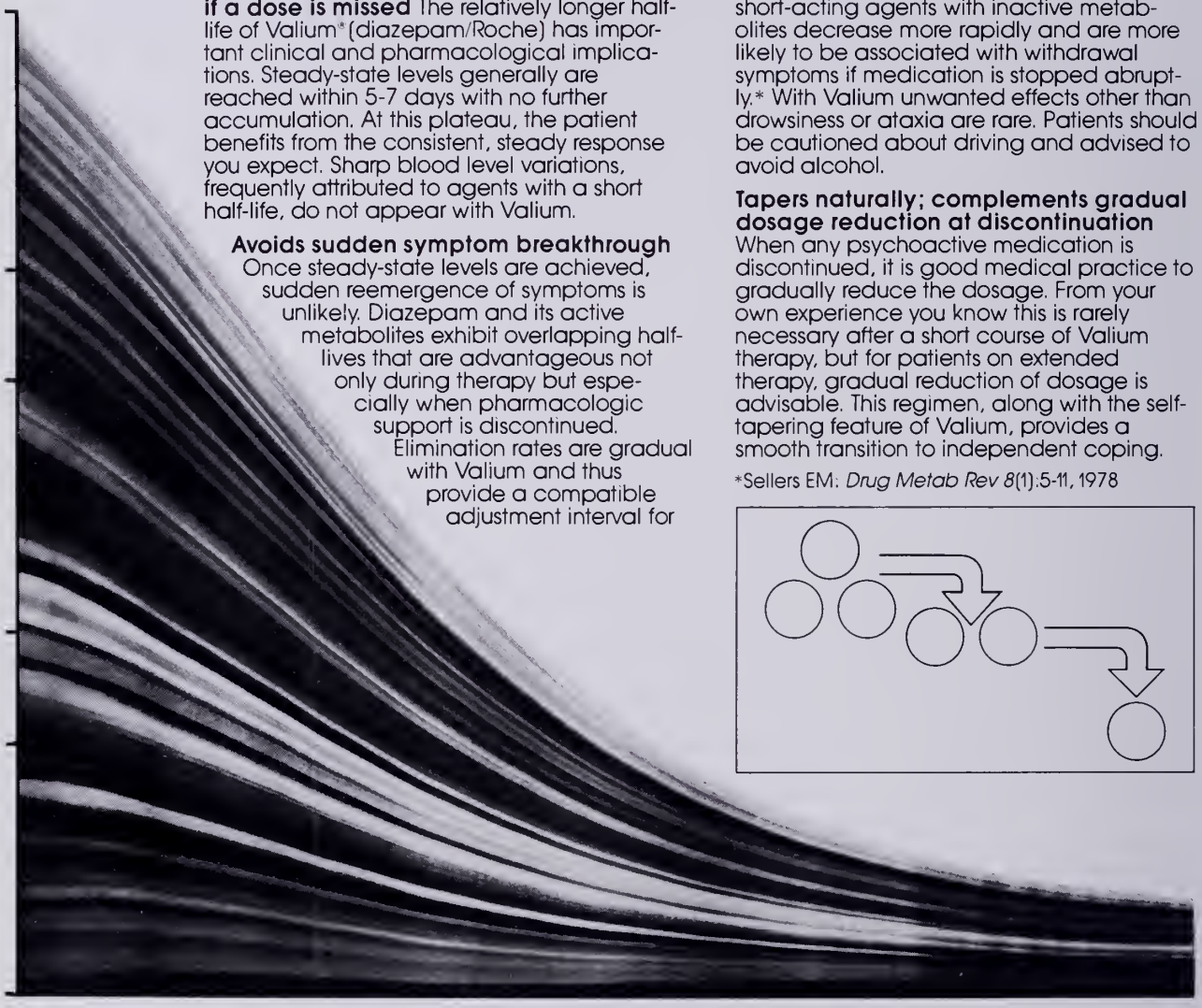
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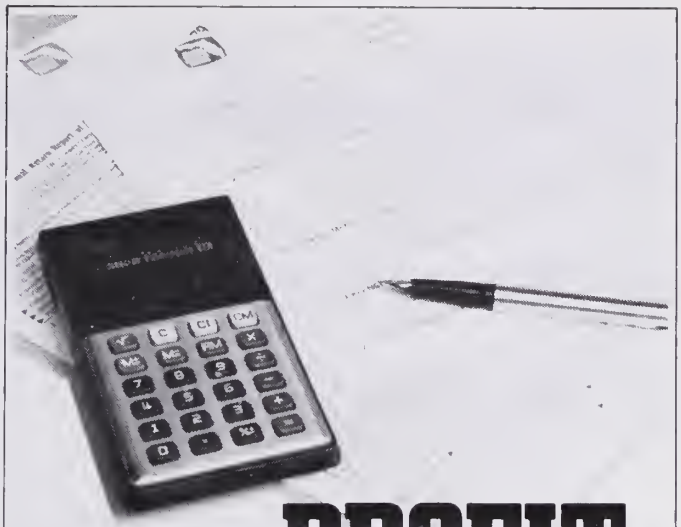
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The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.
Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication, abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
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A scene familiar to Floridians is depicted on the cover this month. The watercolor, commissioned by Strickland's Mayport (a Mayport, Florida restaurant), was created by J. Everett Draper, A.W.S., Ponte Vedra, Florida.

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President's Page

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By the time you read this column the elections will be over for another year. We will have selected the President who will lead us for the next four years and, equally as important, we will have chosen the congressmen and state and local officials who will play as great a part in our lives as the President.

I trust we will have chosen well and that whatever the people's choice, you and I will be able to look back at 1980 and say we did our best. We supported our candidates with money and effort by discussing our beliefs with those we serve. Physicians, by their numbers, make up only a small segment of our society. Their individual and collective influence can be great.

For us to be effective we must have a patient-physician relationship built on trust and affection. These two traits do not come with medical diplomas. They are earned. Doctors preceding us who made our profession what it is through their efforts gave us a start toward trust and affection with our patients. We must build on that start by providing service with understanding.

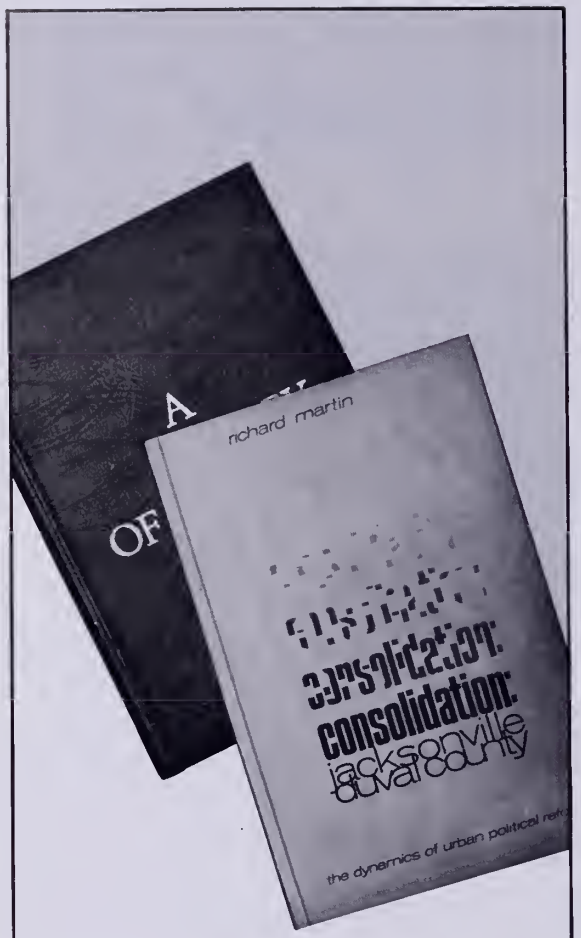
The scientific aspects of medicine have made quantum leaps in the past few decades. In some cases it has made these leaps at the expense of the individual doctor-patient-family relationship. Increasing knowledge in a limited field is only partly of benefit to our patients if we cannot add empathy, personal interest and sympathy when it is needed. In the greatly demanding society in which we presently live, these needs are greater than ever. Stress is not limited to physicians. All of society has increased stress today. Personal concern for our patients helps them to cope with stress.

As a family physician for more than 20 years, I find it easy to become aware of my patients' personal desires and feelings and recognize these effects on their health. But I also know many talented specialists who make it a part of their practice to listen to and share with the patient. They enhance the image we all would like to have as a physician. They emphasize "Care with Caring".

Patients who feel their doctors treat them with skill and caring are less likely to go the legal route when something unforeseen occurs. They are concerned about Government interference with the private relationship we have with patient and doctor. They are anxious to help us continue the historic practice of the best medicine in the world enjoyed by Americans. Our concerns are their concerns.

Don't expect your colleagues to build the image of medicine for you. Continue to upgrade your medical skills with continuing medical education. Continue to upgrade your personal relations with patients by "Care with Caring". You will obtain more satisfaction from your very demanding profession and your patients will be receiving quality care each of us wishes to provide.

T. Byron Thomas M.D.



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CYCLAPEN®-W (cyclacillin)

Indications
Cyclocillin has less in vitro activity than other drugs in the ampicillin class and its use should be confined to these indications: Treatment of the following infections:

RESPIRATORY TRACT
- Tonsillitis and pharyngitis caused by Group A beta-hemolytic streptococci
- Bronchitis and pneumonia caused by S. pneumoniae (formerly D. pneumoniae)
- Otitis media caused by S. pneumoniae (formerly D. pneumoniae) and *H. influenzae*
- Acute exacerbation of chronic bronchitis caused by *H. influenzae**

*Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzae*.

SKIN AND SKIN STRUCTURES (integumentary) infections caused by Group A beta-hemolytic streptococci and staphylococci, non-penicillinase producers.

URINARY TRACT INFECTIONS caused by *E. coli* and *P. mirabilis*. (This drug should not be used in any *E. coli* and *P. mirabilis* infections other than urinary tract.)

NOTE: Perform cultures and susceptibility tests initially and during treatment to monitor effectiveness of therapy and susceptibility of bacteria. Therapy may be instituted prior to results of sensitivity testing.

Contraindications Contraindicated in individuals with history of an allergic reaction to penicillins.

Warnings Cyclacillin should only be prescribed for the indications listed herein.

Cyclacillin has less in vitro activity than other drugs of the ampicillin class. However, clinical trials demonstrated it is efficacious for recommended indications.

Serious and occasional fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin. Although anaphylaxis is more frequent following parenteral use, it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with history of sensitivity to multiple allergens. There are reports of patients with history of penicillin hypersensitivity reactions who experienced severe hypersensitivity reactions when treated with a cephalosporin. Before penicillin therapy, carefully inquire about previous hypersensitivity reactions to penicillins, cephalosporins and other allergens. If allergic reaction occurs, discontinue drug and initiate appropriate therapy. Serious anaphylactoid reactions require immediate emergency treatment with epinephrine. Oxygen, I.V. steroids, airway management, including intubation, should also be administered as indicated.

Precautions Prolonged use of antibiotics may promote overgrowth of nonsusceptible organisms. If superinfection occurs, take appropriate measures.

PREGNANCY: Pregnancy Category B. Reproduction studies performed in mice and rats at doses up to 10 times the human dose revealed no evidence of impaired fertility or harm to the fetus due to cyclacillin. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, use this drug during pregnancy only if clearly needed.

NURSING MOTHERS: It is not known whether this drug is excreted in human milk. Because many drugs are, exercise caution when cyclacillin is given to a nursing woman.

Adverse Reactions Oral cyclacillin is generally well tolerated. As with other penicillins, untoward sensitivity reactions are likely, particularly in those who previously demonstrated penicillin hypersensitivity or with history of allergy, asthma, hay fever, or urticaria. Adverse reactions reported with cyclacillin: diarrhea (in approximately 1 out of 20 patients treated), nausea and vomiting (in approximately 1 in 50), and skin rash (in approximately 1 in 60). Isolated instances of headache, dizziness, abdominal pain, vaginitis, and urticaria have been reported. (See WARNINGS) Other less frequent adverse reactions which may occur and are reported with other penicillins are anemia, thrombocytopenia, thrombocytopenic purpura, leukopenia, neutropenia and eosinophilia. These reactions are usually reversible on discontinuation of therapy.

As with other semisynthetic penicillins, SGOT elevations have been reported.

As with antibiotic therapy generally, continue treatment at least 48 to 72 hours after patient becomes asymptomatic or until bacterial eradication is evidenced. In Group A beta-hemolytic streptococcal infections, at least 10 days' treatment is recommended to guard against risk of rheumatic fever or glomerulonephritis. In chronic urinary tract infection, frequent bacteriologic and clinical appraisal is necessary during therapy and possibly for several months after. Persistent infection may require treatment for several weeks.

Cyclacillin is not indicated in children under 2 months of age.

Patients with Renal Failure Cyclacillin may be safely administered to patients with reduced renal function. Due to prolonged serum half-life, patients with various degrees of renal impairment may require change in dosage level (see DOSAGE AND ADMINISTRATION in package insert).

Dosage (Give in equally spaced doses)

INFECTION	ADULTS	CHILDREN*
Respiratory Tract Tonsillitis & Pharyngitis	250 mg q.i.d.	body weight < 20 kg (44 lbs) 125 mg q.i.d. body weight > 20 kg (44 lbs) 250 mg q.i.d.
Bronchitis and Pneumonia		
Mild or Moderate Infections	250 mg q.i.d.	50 mg/kg/day q.i.d.
Chronic Infections	500 mg q.i.d.	100 mg/kg/day q.i.d.
Otitis Media	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day†
Skin & Skin Structures	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day†
Urinary Tract	500 mg q.i.d.	100 mg/kg/day

*Dosage should not result in a dose higher than that for adults.
†depending on severity

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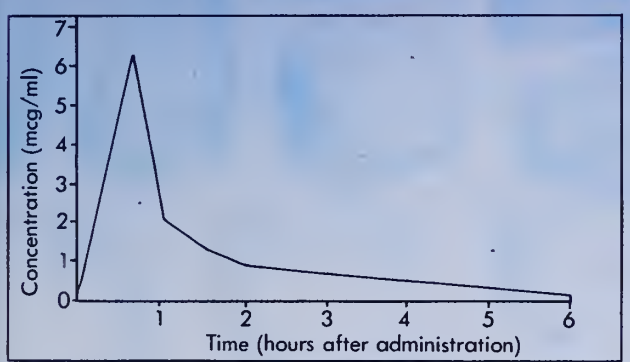
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- Rapidly excreted unchanged in urine – 1½ times faster than ampicillin

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Chronic Bronchitis† (acute exacerbation)		
H. influenzae	92% — Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzae*	12
Streptococcal Sore Throat†		
Group A beta-hemolytic Streptococcus	100% / 86%	44
% Clinical Response / % Bacterial Eradication		

†Due to susceptible organisms.

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*Based an single oral doses af 500 mg cyclacillin tablet and 500 mg ampicillin capsule. Data on file, Wyeth Labaratories.

See important information on facing page.

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Dean's Page

Is There An Oversupply?

Emanuel M. Papper, M.D.

Everyone has had the opportunity of reading in the public press and hearing on television the fact that it is now believed by the authorities of the Federal Government that we have too many physicians in the United States and certainly, will have a considerable surplus by 1985 and an even larger surplus by 1990.

This article is not being written to debate the pros and cons of that particular statement, but to examine something of the process by which it comes into being and some of the consequences of that process upon our lives and the practice of medicine.

It was not very many years ago when, as a matter of public policy, it was decided also in Washington, that we had too few physicians and especially too few in the fields of primary care and that we were in short supply of physicians in rural, ghetto and other underserved areas.

In order to answer this national problem — which in the minds of some, at least, has reached crisis proportions — the schools of medicine were encouraged, required and provided with various kinds of incentives to increase the enrollments of their student bodies. In some instances, new schools were authorized or encouragement was given to their planning. In short, a massive national effort was pushed forward to increase the number of physicians who might be available for the care of the population of the United States.

While all this was going on, there were substantial numbers of foreign medical graduates entering the country, usually by the route of securing training in one or another residency program and then remaining in the United States. There were other routes of entry as well.

At one point, in fact, the number of foreign medical graduates entering the medical care system in the United States was a very large, but still a minority, number of the total who began to care for patients in this country.

Dr. Papper is Vice President for Medical Affairs and Dean of the School of Medicine, University of Miami, Miami, Florida.

It should have been obvious to many, but apparently was not, that a massive system like the medical care of a large population of over 200 million people cannot be fine-tuned in the way that a much simpler apparatus can be. It is clear that technical advances or changes, differences in attitudes of society towards what is needed and what is required for medical care and shifts in population are only a few examples of the kinds of societal forces that can markedly impact the number of physicians required for the care of a nation in either direction.

No attempt is being made to critize those who have decided that new physicians in major numbers had to be created, but a very serious criticism should be levelled at all of us, who are willing to behave in a "crisis management" mode all the time when it is clear that the best possible approach to any large and important problem of this sort is to do the best one can to define the problem itself and then to define the goals and to take those steps necessary to meet the goals allowing for pendulum swings. We must also attempt to adjust as we go along, depending on the changes that cannot be foreseen at the beginning.

In any event, one can certainly forecast, with reasonable certainty, that the surfeit allegedly developing of the number of physicians will cause a serious retrenchment in the support of schools of medicine throughout the country. It will prevent the development of new schools and it has already had a markedly negative impact on the training and education of foreign physicians in our country, despite many important reasons why this should be done and have them return to their native lands. The ripple effects seem to be moving from Washington to the 50 state capitals and one is seeing an increased negativism towards the schools of medicine and toward their fiscal support from both the Federal Government and already in many instances, the State Government, as well. There will be an increased resistance to the necessary tuitions and there will be great questioning of the form of medical education, as to why it

is as expensive as it is.

Another interesting phenomenon in this whole mix is the fact that, despite the evidence believed by most that there will be an excess of supply of physicians, there are still many Americans who cannot gain admission under the present circumstances to medical schools, who go abroad to institutions of varying quality in Central and South America and to the Caribbean areas. Some of the quality is excellent, of course, and some of it is not. But the desire to receive a medical education is overwhelming. Such desires seem to occur also in communist and socialist societies so this movement does seem to be a mystique about the acquisition of a medical education which has little or nothing to do with the securing of employment thereafter. Each one for some reason believes that he will be fortunate enough to make the vast sums of money alleged to be common place amoung physicians in private practice in this country.

It seems to this observer that the practicing physicians of the State of Florida ought to join with their three schools of medicine in recognizing the kind of rapid social drift that has occurred in this one particular problem of the number of physicians who come into practice in this State. There is little question that either fine or gross tuning by Government does not work at all. There seems also to be sufficient evidence to say that the free market place does not determine where people should practice. What determines the required number is unknown. However, it does seem reasonable that in our State no drastic measures, without careful study should be taken to undermine the fiscal stability of the three Schools of Medicine, which have reached a position ranging from respectability to eminence over the course of the years.

● Dr. Papper, University of Miami School of Medicine, Box 875, Biscayne Annex, Miami, Florida 33152.

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Adverse Reactions: Serious side effects have not been found. Some sublingual irritation, transient nausea, and gastric disturbances have been reported. Hydergine tablets and sublingual tablets do not possess the vasoconstrictor properties of natural ergot alkaloids.
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SATURDAY, NOVEMBER 22, 1980

"Electronics and Artifacts" — Dr. Harley Schear, Associate Director of Neurosciences, Mt. Zion Hospital, San Francisco, California

"Range of Normal Variation: Children and Adults" — Dr. Thomas Browne, Assistant Professor of Neurology, Boston Univeristy School of Medicine, Chief, Seizure Unit and EEG Lab, Boston VA Medical Center, Clinical Instructor in Neurology, Harvard Medical School, Boston, Massachusetts

"Maturation of the EEG — Premature and Neonate, Infant, and Child EEG" — Dr. John Hughes, Professor of Neurology, University of Illinois School of Medicine, Chicago, Illinois

"Paroxysmal EEGs and Epilepsy" — **Dr. Henri Gastaut,** Professor of Neurology, Hospital De La Cimond, Marseille, France. Neurological Institute International Guest Speaker

"The Generally Slow EEG" — **Dr. Frederic Gibbs,** Professor Emeritus, Department of Neurology, University of Illinois School of Medicine, Chicago, Illinois

"Focal Slowing on the Electroencephalogram" — Dr. J. Garvin, Professor and Chairman, Department of Neurology, University of Illinois School of Medicine, Chicago, Illinois

Round Table Discussion on "Difficult EEG Interpretation" — Drs. F. Gibbs, H. Gastaut, and J. Garvin, J. Hughes, T. Browne, and H. Schear. Bring your own difficult EEGs!

SUNDAY, NOVEMBER 23, 1980

"Efficient Management of the Private or Institutional EEG Laboratory" — Mr. James Ramsey, Management Consultant, Jacksonville, Florida.

"Abnormal Records in Infants and Children" — Dr. James Nealis, Clinical Assistant Professor of Pediatric Neurology, University of Florida School of Medicine, Jacksonville, Florida

"Cerebral Death and Electro-Cerebral Silence" — Dr. Robert Weinmann, Associate Editor, *Clinical EEG*, San Jose, California

"The Role of EEG as Compared to Other Diagnostic Modalities in Cerebrovascular Disease" — Dr. O. M. Reinmuth, Professor and Chairman, Department of Neurology, University of Pittsburgh School of Medicine, Pittsburgh, Pennsylvania

"The Physiologic and Technical Aspects of Recording Evoked Potentials" — Dr. R. Eugene Ramsay, Assistant Professor of Neurology, University of Miami School of Medicine, Director of Clinical Physiology, VA Hospital, Miami, Florida

"The Clinical Aspects of Evoked Potentials" — Dr. Robert Young, Associate Professor of Neurology at Mass General Hospital, Harvard Medical School, Associate Neurologist and Director at the Clinical Neurophysiology Laboratory Movement Disorder Clinic, Mass General Hospital, Boston

Round Table Discussion on "Evoked Potentials" — Drs. Ramsay and R. Young

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Professional Liability Legal Update

Consent and the Minor Patient

When a person under the age of 18 enters a hospital or doctor's office and seeks an examination, medical treatment, or a surgical operation, the physician is faced with the problem of obtaining valid consent necessary to proceed. The Common Law of the State of Florida classifies any individual under 18 years of age as a minor and considers them to be incompetent to give valid consent to medical treatment and care. The physician faced with such a situation would normally obtain the necessary consent from the minor's parents or guardian. Under certain well-defined circumstances, however, the statutes of Florida allow physicians to proceed without the consent of the minor's parent or guardian.

If the prospective patient is under 18 years of age and is married, has been married, or subsequently becomes married, he or she is to be considered an adult, and the physician may proceed solely upon obtaining the patient's own consent.

If the prospective patient requires emergency medical care or treatment due to injury in an accident or the suffering of an acute illness, disease, or condition, and treatment or care is to be provided in a hospital or college health center, the physician may proceed without the consent of the minor's parent or guardian so long as if, within a reasonable degree of medical certainty, delay would endanger the health of the minor. Prior to proceeding, however, the physician must have attempted to locate the parents, guardian, or legal custodian, by telephone at their residence or place of business or have been unable to do so due to the inability to obtain the necessary information from the minor.

Where the minor patient is, or alleges to be, afflicted or to have come into contact with a veneral disease and seeks medical or surgical care by a hospital or public clinic or the performance of medical or surgical care or services by a physician, the hospital or physician may proceed on the minor's consent alone. Likewise, in the event that the patient requires rehabilitative or medical treatment for drug abuse or dependency, a private physician, hospital, or public clinic may proceed with such treatment after obtaining the consent of the minor.

Neither the patient's consent nor the consent of the patient's parent or guardian is required if the minor has been adjudicated delinquent by a court of competent jurisdiction and the court orders that the child be treated by a physician, psychiatrist, or psychologist. The same also holds true in the event that the court makes such an order after a petition for delinquency has been filed against the child.

Special circumstances exist when the minor patient is female and specifically requires or requests care or treatment for certain conditions. Such needs include the obtaining of information and services relating to maternal health care and contraception and the obtaining of treatment relating to the ongoing care as well as the termination of pregnancy.

Where the minor female patient is married, pregnant, or a parent, or may, in the opinion of the physician, suffer probable health hazards if services are not provided, and the minor requests or requires maternal health and contraceptive information and services of a nonsurgical nature, the physician may provide such with the minor's consent.

Where the minor female patient is unmarried and pregnant, medical, surgical, or other pregnancy-related services may be performed by a hospital, clinic, or licensed physician solely with the minor's consent. In addition, when the unwed, pregnant minor becomes a mother, the performance of any medically-related services on her child is allowed if only her consent is obtained.

If the minor, female patient is pregnant and desires the termination of her pregnancy, obtaining her consent alone is ordinarily not sufficient for proceeding. If she is unmarried, the physician must obtain a written informed consent from the minor, plus either a written informed consent of a parent, custodian, or legal guardian of the minor, or an order of the Circuit Court on petition from the minor, or a person on her behalf, authorizing the termination of pregnancy.* If the minor is married, the physician must obtain either a written consent from the husband or a written statement from the minor confirming that she has given her husband notice of and an

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Prepared and submitted by John E. Thrasher, J.D., Vice President and Legal Counsel; Anthony J. McNicholas, III, J.D., Associate Legal Counsel, Professional Insurance Management Company (PIMCO), Jacksonville, Florida and Dekle Day, Third Year Law Student, Florida State University.

opportunity to consult with her about the termination.* If the woman and the husband are estranged, the physician must obtain a written statement from the wife that the husband is voluntarily living apart or estranged from her. If an emergency situation exists, the above requirements do not hold, and the physician must merely obtain a corroborative medical opinion attesting to the necessity of the emergency procedure and to the fact that the continuation of pregnancy would, to a reasonable degree of medical certainty, threaten the life of the minor.

When a physician is faced with a prospective patient who is under the age of 18 and whose treatment or care does not fall within one of the above-delineated circumstances, the safest practice would be to refrain from proceeding until consent is obtained from the minor's parent or guardian.

*Failure to comply with these provisions may expose the physician to criminal liability for the commission of a third degree felony. However, the federal district court for the Southern District of Florida has declared these provisions as drafted to be unconstitutional and has recommended that the state refrain from enforcing them. *Scheinberg v. State,* 482 F.Supp. 529 (S.D.Fla. 1979).

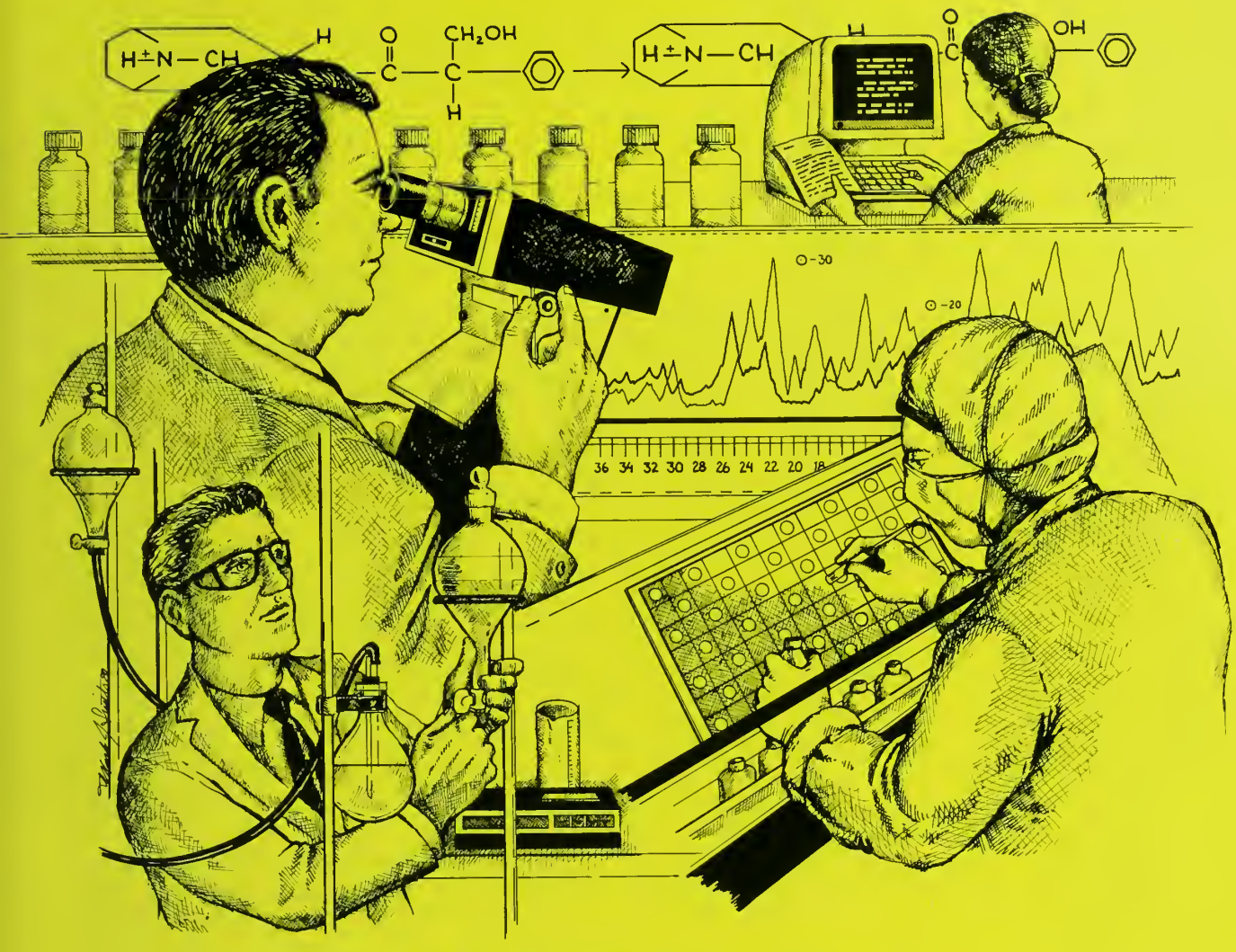
Twenty-Five Years Ago

In *The Journal of the Florida Medical Association* for November 1955:

Roberts Davies, M.D., of Tallahassee, wrote on "Outpatient Treatment of Tuberculosis" for the scientific section . . . **Mr. H. A. Schroder,** Executive Director of the Florida Blue Shield Plan, discussed "Blue Shield's New Increased Fee Schedule" in an address to the Dade County Medical Association . . . The Escambia County Medical Society presented the Pensacola Community Chest a check for $7,250, the largest donation so far from the medical division of the local Red Feather campaign . . . **Richard G. Connar, M.D.**, of Tampa, later to become an American Medical Association delegate from Florida and a member of the AMA Council on Medical Education, was listed as among new members of the FMA . . . **G. Dekle Taylor, M.D.**, of Jacksonville, was appointed a member of the Duval County Welfare Board . . . Tampa Bay area physicians **Mason Trupp, Ernest R. Bourkard, H. Phillip Hampton,** and **Sidney Grau** were principal speakers at the two-day legal institute sponsored by the Tampa and Hillsborough County Bar Association . . .

And so it was in Florida medicine 25 years ago this month. — E.D.H.

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Board of Governors

OF THE

FLORIDA MEDICAL ASSOCIATION

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DONALD C. JONES, Executive Director

Summary of the Board of Governors Meeting
October 23 - 24, 1980

The following is a summary of the actions taken by the Board of Governors at its Fall meeting, October 23 - 24, 1980.

THE BOARD:

1981 Budget

Reviewed the FMA financial statement and proposed 1981 Budget presented by the Treasurer and the EVP which had been reviewed and approved by the Ad Hoc Committee on Finance. It was noted that anticipated income for 1981 would only be 1% higher than the previous year. The Board approved the proposed budget for 1981 with a total anticipated income and expenditures in the amount of $2,135,000.

FMA Property

Directed the EVP to place the proceedings from the sale of the FMA property located at 801 Riverside Avenue after purchase of the new headquarters building at 760 Riverside Avenue in an appropriate depository and prepare an appropriate custodial agreement for approval by the FMA Reserve Trust Committee.

FMA Management

Special Committee on Management

In concurrence with the EVP's request to be relieved of management responsibilities following the 1984 Annual Meeting, the Board authorized that transfer of his responsibilities begin, to be confined to development and implementation of the policies and finances of the Association and related organizations.

The Executive Director shall be primarily responsible for the development, organization, coordination and implementation of the overall activities and programs of the Association including management of the Association's meetings, executive office personnel, administration, communications and accounting, with direct staff responsibilities for the Officers, Executive Committee, Board of Governors, House of Delegates and the AMA Delegation.

The Associate Executive Director/FMA Legal Counsel shall be responsible for and supervise the legal activities of the FMA and public affairs programs which include public relations, legislation and political education activities.

The remainder of the FMA's executive and administrative staff shall be organized in compliance with sound management principles as dictated by Association policies and programs to be developed by the EVP and implemented by the Executive Director.

The Board also directed that the Ad Hoc Committee on Management be continued throughout the management transition period reporting to the Board at least annually regarding progress and additional recommendations. The members of the Committee include: Vernon B. Astler, M.D., Chairman; T. Byron Thames, M.D.; and James B. Perry, M.D. The current President and President-Elect of the FMA will also serve on the Committee.

Attendance at Board Meetings

Directed that County Medical Societies be advised approximately 30 days in advance of each Board Meeting of the general items of business to be included on the agenda and that the CMS President or his designated physician representative be invited to attend the Board Meeting at their own expense to discuss those items that they may be interested in.

The Board reaffirmed current policy of rotating meetings of the Board to different areas of the state and that invitations to attend be extended to the Presidents of surrounding County Medical Societies and their Executives if they desire.

The Board further directed that the policy be reinstated of inviting County Medical Society Executives to attend the FMA Executive Staff Meeting held immediately following Board Meetings to be advised of actions of the Board, and that a member of the Board of Governors also participate in this meeting.

1981 Annual Meeting Format

Approved the format for the 1981 Annual Meeting to be held April 29 - May 3 at the Diplomat Hotel which will include a special symposium on the President's chosen scientific theme of "Stress and Lifestyle".

Council on Specialty Medicine

Patient Transfers

Adopted the following position statement concerning patient transfers:

- The physician requesting the transfer of a patient to a specialized medical facility will be responsible for the care of the patient until the transport team arrives.
- Upon arrival of the transport team, under the direction of the accepting physician, the referring doctor will relinquish responsibility of the patient's care by signing a written statement.
- If a direct referral without the utilization of a transport team is made, the referring physician will assume full responsibility for that transportation.
- The decision to transfer any patient must be made solely by the responsible physician and no patient should be transferred without prior agreement of the receiving physician and the consent of the receiving institution and a copy of pertinent records and/or summary information should accompany the patient in transfer.

Tuberculin Skin Testing

Reaffirmed FMA support of tuberculin skin testing as a routine examination procedure for the detection of TB infection in adults prior to the onset of active disease with the recommendation that those found to be infected either be given preventative drug therapy or evaluated periodically.

Council on Medical Services

State Emergency Medical Services Program

Approved continued efforts to develop a contractual agreement between the Department of HRS and the Florida Medical Foundation for providing the State EMS Office a Medical Director and giving the Foundation the responsibility for planning and development of State EMS Programs.

School Entry Medical Examinations

Approved a recommendation to the Department of Education and the Health Program Office, DHRS, that only M.D.'s and D.O.'s be accepted to certify that a medical or physical examination has been completed under the school entry medical examination law.

Flagging Student Health Records

Directed that FMA send a letter to recognized voluntary health agencies requesting the development of guidelines for handling student chronic health problems or to provide the FMA with information on any such material already in existence.

Judicial Council

Medical and Health Yellow Pages for South Florida

Approved a recommendation not to endorse the publication entitled "Medical and Health Yellow Pages for South Florida" and directed that the membership roster of the Florida Medical Association not be given or sold to the organization publishing this directory.

AMA Delegates

AMA Vice Speaker

Authorized funds for Florida AMA Delegates to promote the candidacy of Dr. Rufus Broadaway for election to the office of Vice Speaker of the AMA in June, 1981.

Impaired Physicians Program

Budget

Authorized an FMA contribution not to exceed $75,000 through the end of calendar year 1981 to the Florida Medical Foundation for implementation of an Impaired Physicians Program.

Confidentiality

Requested the Committee on State Legislation to consider the need for additional legislative guarantees for the confidentiality of records and deliberations on the Committee on Impaired Physicians.

Educational Program

Approved a half-day educational program to be held on Friday, January 30, in conjunction with the FMA Leadership Conference Program itself for a presentation by the Committee.

FMA Auxiliary

Expressed appreciation to the FMA Auxiliary for their continuing fine efforts in behalf of the FMA and the Florida Medical Foundation particularly with regard to legislative educational activities, support of the Impaired Physicians Program and fund raising efforts in behalf of the Florida Medical Foundation.


COUGH
COUGH
COUGH

For Sneezing and Nasal Congestion



RU-TUSS® TABLETS

Each prolonged action tablet contains:

Phenylephrine Hydrochloride	25 mg
Phenylpropanolamine Hydrochloride	50 mg
Chlorpheniramine Maleate	8 mg
Hyoscyamine Sulfate	0.19 mg
Atropine Sulfate	0.04 mg
Scopolamine Hydrobromide	0.01 mg

Ru-Tuss Tablets act continuously for 10 to 12 hours.

- Vasoconstrictor, antihistaminic actions
- Rapid and prolonged relief of nasal and sinus congestion
- Convenient b.i.d. dosage

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For Coughing With Nasal and Bronchial Congestion



RU-TUSS® EXPECTORANT

Each fluid ounce of Ru-Tuss Expectorant contains:

Codeine Phosphate (WARNING: MAY BE HABIT FORMING)	65.8 mg
Phenylephrine Hydrochloride	30 mg
Phenylpropanolamine Hydrochloride	20 mg
Pheniramine Maleate	20 mg
Pyrilamine Maleate	20 mg
Ammonium Chloride	200 mg
Alcohol	5%

- Vasoconstrictor, antihistaminic, expectorant actions with codeine
- Rapid relief of upper respiratory congestion and cough
- Good tasting

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ne Family

SNEEZE

RU-TUSS® TABLETS

DESCRIPTION
Each prolonged action tablet contains:

Phenylephrine Hydrochloride	25 mg
Phenylpropanolomine Hydrochloride	50 mg
Chlorpheniramine Maleate	8 mg
Hyoscyomine Sulfate	0.19 mg
Atropine Sulfate	0.04 mg
Scopolamine Hydrobromide	0.01 mg

Ru-Tuss Tablets act continuously for 10 to 12 hours.
Ru-Tuss Tablets are an oral antihistaminic, nasal decongestant and anti-secretory preparation.

INDICATIONS AND USAGE Ru-Tuss Tablets provide relief of the symptoms resulting from irritation of sinus, nasal and upper respiratory tract tissues. Phenylephrine and phenylpropanolamine combine to exert a vasoconstrictive and decongestive action while chlorpheniramine maleate decreases the symptoms of watering eyes, post nasal drip and sneezing which may be associated with an allergic-like response. The belladonna alkaloids, hyoscyamine, atropine and scopolamine further augment the anti-secretory activity of Ru-Tuss Tablets.

CONTRAINDICATIONS Hypersensitivity to antihistamines or sympathomimetics. Ru-Tuss Tablets are contraindicated in children under 12 years of age and in patients with glaucoma, bronchial asthma and women who are pregnant. Concomitant use of MAO inhibitors is contraindicated.

WARNINGS Ru-Tuss Tablets may cause drowsiness. Patients should be warned of the possible additive effects caused by taking antihistamines with alcohol, hypnotics, sedatives or tranquilizers.

PRECAUTIONS Ru-Tuss Tablets contain belladonna alkaloids, and must be administered with care to those patients with glaucoma, or urinary bladder neck obstruction. Caution should be exercised when Ru-Tuss Tablets are given to patients with hypertension, cardiac or peripheral vascular disease or hyperthyroidism. Patients should avoid driving a motor vehicle or operating dangerous machinery (See Warnings).

OVERDOSAGE Since the action of sustained release products may continue for as long as 12 hours, treatment of overdoses directed at reversing the effects of the drug and supporting the patient should be maintained for at least that length of time. Saline cathartics are useful for hastening evacuation of unreleased medication. In children and infants, antihistamine overdosage may produce convulsions and death.

ADVERSE REACTIONS Hypersensitivity reactions such as rash, urticaria, leukopenia, agranulocytosis, and thrombocytopenia may occur. Other adverse reactions to Ru-Tuss Tablets may be drowsiness, lassitude, giddiness, dryness of the mucous membranes, tightness of the chest, thickening of bronchial secretions, urinary frequency and dysuria, palpitation, tachycardia, hypotension/hypertension, faintness, dizziness, tinnitus, headache, incoordination, visual disturbances, mydriasis, xerostomia, blurred vision, anorexia, nausea, vomiting, diarrhea, constipation, epigastric distress, hyperirritability, nervousness, dizziness and insomnia. Large overdoses may cause tachypnea, delirium, fever, stupor, coma and respiratory failure.

DOSAGE AND ADMINISTRATION Adults and children over 12 years of age, one tablet morning and evening. Not recommended for children under 12 years of age. Tablets are to be swallowed whole.

HOW SUPPLIED:
Bottles of 100 Tablets — NDC 0524-0058-01
Bottles of 500 Tablets — NDC 0524-0058-05
Federal law prohibits dispensing without prescription

COUGH

RU-TUSS® EXPECTORANT

DESCRIPTION
Each fluid ounce of Ru-Tuss Expectorant contains:

Codeine Phosphate	65.
(WARNING: MAY BE HABIT FORMING)	
Phenylephrine Hydrochloride	3
Phenylpropanolomine Hydrochloride	2
Pheniramine Maleate	2
Pyrilamine Maleate	2
Ammonium Chloride	20
Alcohol	

Ru-Tuss Expectorant is an oral antitussive, antihistaminic, nasal decongestant expectorant preparation.

INDICATIONS AND USAGE Ru-Tuss Expectorant is indicated for symptomatic relief upper respiratory congestion associated with pharyngitis, tracheitis, bronchitis allergic rhinitis. Also, for the temporary relief of symptoms associated with hay allergies, nasal congestion and cough due to the common cold.

CONTRAINDICATIONS Hypersensitivity to antihistamines. Concomitant use of an hypertensive or antidepressant drug containing a monoamine oxidase inhibi contraindicated.
Ru-Tuss Expectorant is contraindicated in patients with glaucoma, bronchial as and in women who are pregnant.

WARNINGS Ru-Tuss Expectorant contains codeine phosphate, therefore, the pa should be warned of the potential that this drug may be habit forming. Ru-Tuss E torant may cause drowsiness. Patients should be warned of the possible additive coused by taking antihistamines with alcohol, hypnotics, sedatives and tranquil

PRECAUTIONS Patients taking Ru-Tuss Expectorant should avoid driving a motor ve or operating dangerous machinery (See Warnings). Caution should be taken wi tients having hypertension, diabetes, hyperthyroidism and cardiovascular disea Caution should also be used in patients with pulmonary, hepatic or renal insuffic

ADVERSE REACTIONS Ru-Tuss Expectorant may cause drowsiness, lassitude, gidd dryness of mucous membranes, tightness of the chest, thickening of bronchial s tions, urinary frequency and dysuria, palpitation, tachycardia, hypotension/hyp sion, faintness, dizziness, tinnitus, headache, incoordination, visual disturba mydriasis, xerostomia, blurred vision, anorexia, nausea, vomiting, diarrhea, con tion, epigastric distress, hyperirritability, nervousness and insomnia. Overdose cause restlessness, excitation, delirium, tremors, euphoria, metabolic acidosis, s tachycardia and even convulsions.

DOSAGE AND ADMINISTRATION Adults: 1 or 2 teaspoonfuls, orally, every 4 hours, exceed 10 teaspoonfuls in any 24-hour period.
Children 6 to 12 years of age: ½ the adult dose, not to exceed 6 teaspoonfuls 24-hour period. Children 2 to 6 years of age: ½ teaspoonful every 4 hours, not to ex 3 teaspoonfuls in any 24-hour period. Children under 2 years of age: Use as direct a physician.

HOW SUPPLIED
Pint bottles (16 fl oz) — NDC 0524-10
Federal law prohibits dispensing without prescription

DISTRIBUTED BY:
Boots Pharmaceuticals, Inc.
Shreveport, Louisiana 71106

MANUFACTURED BY:
Vitarine Company, Inc.
Springfield Gardens, New York 11413

Boots Pharmaceuticals, Inc.
Shreveport, Louisiana 71106
Pioneers in Medicine For the Family



WHEN ANXIETY AND TENSION MAGNIFY PAIN

IN MUSCULOSKELETAL DISEASE*

A non-narcotic one-two punch against pain, with concurrent relief of anxiety/tension

EQUAGESIC® ℗

(meprobamate and ethoheptazine citrate with aspirin) Wyeth

EQUAGESIC—Abbreviated Summary

***INDICATIONS:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows

"Possibly" effective for the treatment of pain accompanied by tension and/or anxiety in patients with musculoskeletal disease or tension headache.

Final classification of the less-than-effective indications requires further investigation

The effectiveness of Equagesic in long-term use, i.e. more than four months, has not been assessed by systematic clinical studies. The physician should periodically reassess usefulness of the drug for the individual patient

CONTRAINDICATIONS: Equagesic should not be given to individuals with a history of sensitivity or severe intolerance to aspirin, meprobamate, or ethoheptazine citrate

WARNINGS: Careful supervision of dose and amounts prescribed for patients is advised, especially with those patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g., alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on or habituation to the drug. Where excessive dosage has continued for weeks or months, dosage should be reduced gradually rather than abruptly stopped, since withdrawal of a "crutch" may precipitate withdrawal reaction of greater proportions than that for which the drug was originally prescribed. Abrupt discontinuance of doses in excess of the recommended dose has resulted in some cases in the occurrence of epileptiform seizures

Special care should be taken to warn patients taking meprobamate that tolerance to alcohol may be lowered with resultant slowing of reaction time and impairment of judgement and coordination

USAGE IN PREGNANCY AND LACTATION: An increased risk of congenital malformations associated with the use of minor tranquilizers (meprobamate, chlordiazepoxide, and diazepam) during the first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of child-bearing potential may be pregnant at the time of institution of therapy should be considered. Patients should be advised that if they become pregnant during therapy or intend to become pregnant they should communicate with their physicians about the desirability of discontinuing the drug.

Meprobamate passes the placental barrier. It is present both in umbilical-cord blood at or near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breast-feeding patients, the drug's higher concentrations in breast milk as compared to maternal plasma levels should be considered.

Preparations containing aspirin should be kept out of the reach of children. Equagesic is not recommended for patients 12 years of age and under

PRECAUTIONS: Should drowsiness, ataxia, or visual disturbance occur, the dose should be reduced. If symptoms continue, patients should not operate a motor vehicle or any dangerous machinery

Suicidal attempts with meprobamate have resulted in coma, shock, vasomotor and respiratory collapse, and anuria. Very few suicidal attempts were fatal, although some patients ingested very large amounts of the drug (20 to 40 gm). These doses are much greater than recommended. The drug should be given cautiously, and in small amounts, to patients who have suicidal tendencies. In cases where excessive doses have been taken, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels. Hyperventilation has been reported occasionally. Any drug remaining in the stomach should be removed and symptomatic treatment given. Should respiration become very shallow and slow, CNS stimulants, e.g., caffeine, Metrazol, or amphetamine, may be cautiously administered. If severe hypotension develops, pressor amines should be used parenterally to restore blood pressure to normal levels

ADVERSE REACTIONS: A small percentage of patients may experience nausea with or without vomiting and epigastric distress. Dizziness occurs rarely when meprobamate and ethoheptazine citrate with aspirin is administered in recommended dosage. The meprobamate may cause drowsiness but, as a rule, this disappears as therapy is continued. Should drowsiness persist and be associated with ataxia, this symptom can usually be controlled by decreasing the dose, but occasionally it may be desirable to administer central stimulants such as amphetamine or mephentermine sulfate concomitantly to control drowsiness.

A clearly related side effect to the administration of meprobamate is the rare occurrence of allergic or idiosyncratic reactions. This response develops, as a rule, in patients who have had only 1-4 doses of meprobamate and have not had a previous contact with the drug. Previous history of allergy may or may not be related to the incidence of reactions.

Mild reactions are characterized by an itchy urticarial or erythematous, maculopapular rash which may be generalized or confined to the groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema, and fever have also been reported.

More severe cases, observed only very rarely, may also have other allergic responses, including fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case), and hyperthermia. Treatment should be symptomatic such as administration of epinephrine, antihistamine, and possibly hydrocortisone. Meprobamate should be stopped, and reinstitution of therapy should not be attempted.

Rare cases have been reported where patients receiving meprobamate suffered from aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia. In nearly every instance reported, other toxic agents known to have caused these conditions have been associated with meprobamate. A few cases of leukopenia during continuous administration of meprobamate are reported, most of these returned to normal without discontinuation of the drug.

Impairment of accommodation and visual acuity has been reported rarely.

OVERDOSE: Two instances of accidental or intentional significant overdosage with ethoheptazine citrate combined with aspirin have been reported. These were accompanied by symptoms of CNS depression, including drowsiness and light-headedness, with uneventful recovery. However, on the basis of pharmacological data, it may be anticipated that CNS stimulation could occur. Other anticipated symptoms would include nausea and vomiting. Appropriate therapy of signs and symptoms as they appear is the only recommendation possible at this time. Overdosage with ethoheptazine combined with aspirin would probably produce the usual symptoms and signs of salicylate intoxication. Observation and treatment should include induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which if it occurs, usually requires whole-blood transfusions.

DESCRIPTION: Each Equagesic tablet contains 150 mg meprobamate, 75 mg ethoheptazine citrate and 250 mg aspirin.

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*This drug has been evaluated as possibly effective for this indication.

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Philadelphia, Pa 19101

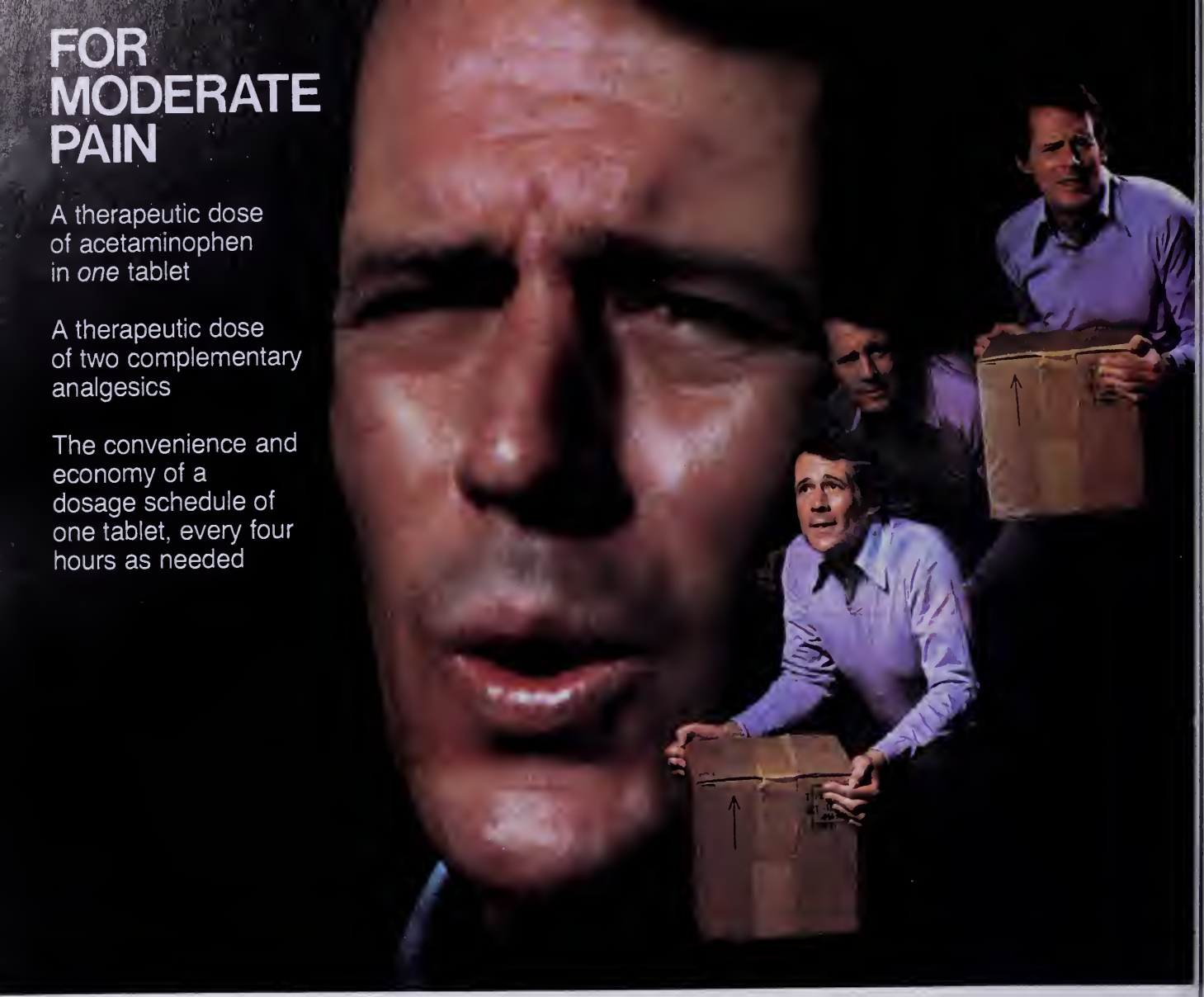
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FOR MODERATE PAIN

A therapeutic dose of acetaminophen in *one* tablet

A therapeutic dose of two complementary analgesics

The convenience and economy of a dosage schedule of one tablet, every four hours as needed



WHY NOT WYGESIC® (IV)

(65 mg propoxyphene HCl and 650 mg acetaminophen) Wyeth

WYGESIC—Abbrevieted Summary

INDICATION: For the relief of mild-to-moderate pain.

CONTRAINDICATION: Hypersensitivity to propoxyphene or to acetaminophen.

WARNINGS: CNS ADDITIVE EFFECTS AND OVERDOSAGE. Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, or other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. Toxic effects and fatalities have occurred following overdoses of propoxyphene alone or in combination with other CNS depressants. Most of these patients had histories of emotional disturbances or suicidal ideation or attempts, as well as misuse of tranquilizers, alcohol, or other CNS-active drugs. Caution should be exercised in prescribing large amounts of propoxyphene for such patients (see **Menegement of Overdosage**).

DRUG DEPENDENCE: Propoxyphene can produce drug dependence characterized by psychic dependence and less frequently, physical dependence and tolerance. It will only partially suppress the withdrawal syndrome in individuals physically dependent on morphine or other narcotics. The abuse liability of propoxyphene is qualitatively similar to codeine's although quantitatively less, and propoxyphene should be prescribed with the same degree of caution appropriate to the use of codeine.

USAGE IN AMBULATORY PATIENTS: Propoxyphene may impair the mental and/or physical abilities required for potentially hazardous tasks, e.g. driving a car or operating machinery. Patients should be cautioned accordingly.

USAGE IN PREGNANCY: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. INSTANCES OF WITHDRAWAL SYMPTOMS IN THE NEONATE HAVE BEEN REPORTED FOLLOWING USAGE DURING PREGNANCY. Therefore, propoxyphene should not be used in pregnant women unless, in the judgement of the physician, the potential benefits outweigh the possible hazards.

USAGE IN CHILDREN: Propoxyphene is not recommended for children because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric group.

PRECAUTIONS: Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine. The CNS depressant effect of propoxyphene may be additive with other CNS depressants, including alcohol.

ADVERSE REACTIONS: The most frequent adverse reactions are dizziness, sedation, nausea, and vomiting. These seem more prominent in ambulatory than in nonambulatory patients; some of these reactions may be alleviated if the patient lies down.

Other adverse reactions include constipation, abdominal pain, skin rashes, light-headedness, headache, weakness, euphoria, dysphoria, and minor visual disturbances. The chronic ingestion of propoxyphene in doses over 800 mg per day has caused toxic psychoses and convulsions. Cases of liver dysfunction have been reported.

DRUG INTERACTIONS: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, and other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. (see **Wernings**) Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine.

MANAGEMENT OF OVERDDSAGE: SYMPTOMS The manifestations of serious overdosage with propoxyphene are similar to those of narcotic overdosage and include respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, pupillary constriction, and circulatory collapse. In addition to these characteristics, which are reversed by narcotic antagonists such as naloxone, there may be other effects. Overdoses of propoxyphene can cause delay of cardiac conduction as well as focal or generalized convulsions, a prominent feature in most cases of severe poisoning. Cardiac arrhythmias and pulmonary edema have occasionally been reported, and apnea, cardiac arrest, and death have occurred.

Symptoms of massive overdosage with acetaminophen may include nausea, vomiting, anorexia, and abdominal pain, beginning shortly after ingestion and lasting for 12 to 24 hours. However, early recognition may be difficult since early symptoms may be mild and nonspecific. Evidence of liver damage is usually delayed. After the initial symptoms, the patient may feel less ill; however, laboratory determinations are likely to show a rapid rise in liver enzymes and bilirubin. In case of serious hepatotoxicity: jaundice, coagulation defects, hypoglycemia, encephalopathy, coma, and death may follow. Renal failure due to tubular necrosis, and myocardiopathy, have also been reported.

Ingestion of 10 grams or more of acetaminophen may produce hepatotoxicity. A 13-gram dose has reportedly been fatal.

TREATMENT: Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation. The narcotic antagonists, naloxone, nalorphine, and levallorphan, are specific antidotes against the respiratory depression produced by propoxyphene. An appropriate dose of one of these antagonists should be administered, preferably IV, simultaneously with efforts at respiratory resuscitation and the antagonist should be repeated as necessary until the patient's condition remains satisfactory. In addition to a narcotic antagonist, the patient may require careful titration with an anticonvulsant to control seizures. Analeptic drugs (e.g. caffeine or amphetamine) should not be used because of their tendency to precipitate convulsions.

Oxygen, IV fluids, vasopressors and other supportive measures should be used as indicated. Gastric lavage may be helpful. Activated charcoal can absorb a significant amount of ingested propoxyphene. Dialysis is of little value in poisoning by propoxyphene alone. Acetaminophen is rapidly absorbed, and efforts to remove the drug from the body should not be delayed. Copious gastric lavage and/or induction of emesis may be indicated. Activated charcoal is probably ineffective unless administered almost immediately after acetaminophen ingestion. Neither forced diuresis nor hemodialysis appears to be effective in removing acetaminophen. Since acetaminophen in overdose may have an antidiuretic effect and may produce renal damage, administration of fluids should be carefully monitored to avoid overload. It has been reported that mercaptamine (cysteamine) or other thiol compounds may protect against liver damage if given soon after overdosage (8-10 hours). N-acetylcysteine is under investigation as a less toxic alternative to mercaptamine, which may cause anorexia, nausea, vomiting, and drowsiness. Appropriate literature should be consulted for further information. (JAMA 237:2406-2407, 1977)

Clinical and laboratory evidence of hepatotoxicity may be delayed up to one week. Acetaminophen plasma levels and half-life may be useful in assessing the likelihood of hepatotoxicity. Serial hepatic enzyme determinations are also recommended.

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Philadelphia, Pa. 19101

Editorial

Variety Children's Hospital — Three Decades of Service

With the year 1980 Variety Children's Hospital in Dade County began its fourth decade of service to children. This hospital, Florida's oldest and largest devoted solely to the care of children, offers the most advanced services in pediatric medicine and surgery. As a center for teaching and research in pediatrics it has acquired an international reputation.

In the field of pediatric medicine its staff offers outstanding men and women in neonatology, cardiology, endocrinology, neurology, hematology, oncology and psychiatry. The surgical staff is particularly strong in general pediatric surgery, orthopedics, cardiac surgery, urology and ophthalmology.

As a center for teaching and research the hospital offers an approved three-year pediatric residency and participates in the training of the residents from the University of Miami/Jackson Memorial Medical Center and the Mt. Sinai Hospital of Miami Beach. Each winter the hospital sponsors a four-day postgraduate course in pediatrics, one of the best attended in this country and possibly in the world.

Variety Hospital is the fulfillment of a dream of a group of civic-minded women who became concerned about the care of indigent crippled children in South Florida. In 1927 these ladies set about to raise funds for the care and rehabilitation of such children. They enlisted the aid of Dr. Arthur H. Weiland, then the only surgeon south of Jacksonville who limited his practice to orthopedics. In 1929 the American Legion and other interested parties brought about the establishment of the Florida Crippled Children's Commission, a joint state and federal agency. An auxiliary of this commission in 1932 established the South Florida Crippled Children's Society. It was they who began the planning of a children's hospital. At that time this society operated an outpatient clinic in Coral Gables with a single paid employee, Mrs. Nell Reimer, R.N., and were allotted four beds at the Jackson Memorial Hospital. Over the next several years this society together with Dr. Weiland and Mrs. Reimer solicited funds from individuals and business organizations and cared for a large number of indigent children. Finally, in an effort to render better care, on July 4, 1940, the South Florida Children's Hospital, Inc., was organized by this group of concerned citizens. A number of Miami's outstanding business and professional people became involved and a considerable sum of money was accumulated.

The present site of the hospital, then 26 acres of scrub and pine land west of Coral Gables, was purchased in 1940 and construction of the initial building begun in late 1940 or early 1941. The construction was a charitable community effort; the building trades businesses donated concrete blocks, lumber, hardware, etc., organized labor donated untold man hours, and a contractor, Mr. Joseph Orr, and his associates donated the supervision of construction. Things were moving right along when suddenly on December 7, 1941, the Japanese struck Pearl Harbor and construction ceased for the duration of World War II.

With the return of peace the hospital's loyal supporters regrouped under the leadership of Col. Robert Pentland Jr. and set out to complete the structure. Largely due to the influence of Mr. George C. Hoover, the Miami Tent No. 33 of the Variety Clubs International joined in the project and accepted responsibility for the fiscal support of the hospital. In return the hospital became known as the Variety Children's Hospital.

With donated funds and a federal grant of $150,000. the initial building was completed at a total cost of $250,000., and was dedicated February 10, 1950. The first patients were transfers from the inadequate facilities at the Jackson Memorial Hospital. Initially most of the patients were victims of infantile paralysis which was rampant in South Florida at that time. The disease was also epidemic throughout the Caribbean, Central and South America, and soon little patients were being flown in from these areas and supplies, even to iron lungs, were being flown to these areas. At that time one of the most

up-to-date virus isolation and identification laboratories was a part of the hospital's services.

The Salk vaccine (1955) and the Sabine vaccine 1961) have changed all that and poliomyelitis has become much less frequent. With the decline in polio the Variety Hospital became more of a general pediatric hospital and the services expanded both for the inpatients and for the some 35,000 outpatients now receiving care each year. As these changes began to take place Hill-Burton funds were obtained permitting the addition of two wings, dedicated on February 28, 1965, that increased the bed capacity to the present 188 beds. Finally, in the 1970's a neonatal intensive care facility and enlarged laboratories for pathology, hematology, and oncology were constructed.

We of the Florida Medical Association extend our congratulations to our colleagues who have build and staffed this outstanding institution. May the years ahead bring continued growth and service.

William M. Straight, M.D.
Historical Editor
Miami



Fifty Years Ago

In *The Journal of the Florida Medical Association* for November 1930:

M. J. Myres, M.D., of Daytona Beach, described "Two Aspects of Hypertension" in the scientific section . . . In a letter to members, the FMA Executive Committee announced that a contract had been negotiated with United States Fidelity and Guaranty Company of Baltimore to provide medical malpractice insurance. Maximum coverage of $50,000/$150,000 was made available at a basic premium of $29.22. "Each practicing physician should carry liability insurance for the number of malpractice suits seems to be on the increase," *The Journal* suggested . . . **H. Mason Smith, M.D.**, of Tampa, was elected President of the State Board of Health . . . **L. L. Andrews, M.D.**, of Orlando, was installed as President of the Florida Midland Medical Society at its Annual Meeting in Orlando . . . Contemplating a trip abroad, **John Blake White, M.D.**, resigned as House Physician at the Hotel Ormond in Ormond Beach, a position he held for 23 years . . . The Medical Study Club of Orlando announced that **H. C. Bumpus, M.D.**, a Mayo Clinic neurologist, would speak at the organization's December meeting . . .

And so it was in Florida Medicine 50 years ago this month. — E.D.H.

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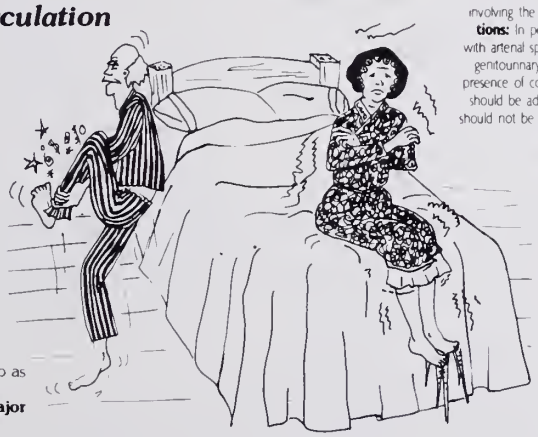
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Putting Tests to the Test

Sonja Lessne, M.D.

We are in an age concerned with humanism, ethics and cost effectiveness in medical care. The admonition, primum non-nocere, applies to economic and psychological as well as to physical parameters of patient care. Biomedical studies ordered or interpreted inappropriately can result in problems which can cause harm economically, psychologically and physically.

Using biomedical technology appropriately is not easy. Medical education does not systematically provide physicians with the skills to use and interpret biomedical procedures.[1] Data regarding the efficacy of new tests or procedures often appear in nonmedical journals, written by biochemists or pharmacologists and may be difficult for physicians to interpret or understand. This article is an attempt to overcome these problems, to review factors which affect biomedical studies, and to give a working knowledge and understanding of the concepts of the diagnostic and predictive values of tests.

Laboratory tests are affected by (1) specimen collection; (2) quality control in the laboratory; (3) clerical errors, and (4) patient factors. Laboratory results are very much dependent on appropriate collection of specimens. Urine cultures improperly collected or incorrectly handled give unreliable results and are a waste of time and money. Rough handling can cause hemolysis of blood cells resulting in serum unusable for analysis. Collecting blood in the wrong tube can cause added expense, discomfort and inconvenience for the patient and embarrassment for the physician.

The importance of laboratory quality control and its effects is illustrated by the fact that runs of unusually high or confusingly abnormal returns on lab studies are followed by letters explaining that these abnormalities are artifacts. Laboratories are extremely complex scientific industries which do a good job considering the enormity of their business, but the possibility of technical problems do exist.

"Normal and Abnormal"

To consider patient factors when assessing laboratory studies, it is necessary to understand the concepts of normal and abnormal. Generally, normal as applied to many laboratory tests and biomedical procedures represents a range of values which includes 95% of the individuals free of disease. Thus, to calculate the normals for a test, investigators locate a population believed to be disease free, perform the test, and plot the results. Then they calculate a range of normal which includes the central 95% of this plotted population.* Upper and lower limits of normal are a matter of the investigator's judgment as long as the range includes 95% of the population.

Normal and abnormal test results are often unrelated to the presence or absence of disease.[2-4] An abnormal test may belong to a person who is normally abnormal (i.e., in the 5% outside the range considered normal by investigators).

Abnormal results may also be a consequence of normal physiological changes such as occurs in aging, and pregnancy, effects of medication, diseases, genetic variation, diet and physical activity (Table 1).

Idiosyncratic responses to medication can cause

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*This way of establishing normals is based on Gauss' law of errors which states that repeated measures on the same object would result in the old familiar bell-shaped curve. This has nothing to do with human biologic variation.

abnormal lab tests based on a true disruption of physiological function. For example, isoniazid and methyldopa can cause hepatitis. In these cases, liver function tests are compatible with a diagnosis of hepatitis and reflect true dysfunction of the liver based on the toxic effect of the medication. However, laboratory reagents also suffer an idiosyncratic response to the presence of isoniazid and/or methyldopa in the blood and urine. Isoniazid, for example, can cause a positive glucose (clinitest) test on the urine secondary to its effect on reagents. Methyldopa can cause increased serum bilirubin, serum creatinine, and serum glucose secondary to its effects on reagents used to perform the tests.[5]

Presence of a Disease

Normal and abnormal lab tests should be considered in terms of probability of correlation to disease or nondisease states rather than equated with diseased or disease free states. Increased serum bilirubin is often associated with disease but may not reflect disease at all. Elevated blood sugar may mean a chronic disease process, but then again it may not. Normal test results do not assure freedom from the disease tested. Normal uric acid does not mean gout-free, normal chest x-ray cannot assure freedom from lung pathology, and normal cholesterol may have no meaning at all.

In order to evaluate test results it is necessary to understand the inherent value of the test and the effect of disease prevalence on those test results. The concepts which allow this understanding are called the diagnostic and predictive values of tests.

The diagnostic value of a test is its ability to help the physician to separate people with disease from people without disease. The ability is described in terms called sensitivity and specificity.

Sensitivity* — Measures the proportion of people with the disease called positive by the test. A test with 100% sensitivity has no false negative; everybody who has the disease is called positive by the test. A test with 95% sensitivity has 5% false negatives (5% of people with the disease are missed by the test).

Specificity** — Measures the proportion of people who do not have the disease and are called negative by the test. A test with 100% specificity has no false positives. Everybody who does not have the disease is called negative by the test. A test with 95% specificity has 5% false positives. (5% of people without the disease are called positive by the test).

Sensitivity and specificity of a test are determined on a population with a 50% disease prevalence. For example, the test population will consist of 1,000 people, 500 with disease, 500 without the disease; prevalence is 500/1000, or 50%. Let's determine the sensitivity and specificity of a hypothetical test on 1,000 people with a 50% prevalence of the disease we are testing for.[6] The test is given to all 1,000 people. We find that 400 of the diseased people are called positive by the test, and 450 of the nondiseased people are called negative by the test.

Table 1. — Nondisease Causes of Abnormal Laboratory Tests.

Cause	Test Affected
Diet	blood glucose
	uric acid
	cholesterol
	blood lipids
Unrelated Illness	Serology for Syphillis
	Falsely positive when patient has infectious mononucleosis
	Total Serum T_4[4]
	Lower in "sick" people
	Total Serum T_3[4] — MI, Elective Surgery — decreased
Pregnancy	T_4
	glucose tolerance
	etc. (Endocrine tests)
Vigorous Physical Activity	BUN (elevated)
	SGOT (elevated)
	Urinalysis
	proteinuria
	hematuria
Genetic Idiosyncrasy	Urinalysis (orthostatic proteinuria)
	Bilirubin (Idiopathic unconjugated bilirubinemia)
Medication[5]	Clinitest (isoniazid affects reagent)
	Serum bilirubin, Serum creatinine, Serum glucose — Methyldopa affects reagent
Age	Serum albumin
	Glucose tolerance test
	Sed rate
	Hemoglobin

*A highly sensitive test has few false negatives; remember this by the fact that sensitive and negative have "n's" in their spelling.

**A highly specific test has few false positives; remember this by the fact that specific and positive both have "p's" in their spelling.

$$\text{Sensitivity} = \frac{400 \text{ (correctly called (+) by the test)}}{500 \text{ (\# of people with the disease)}} = 80\%$$

$$\frac{100 \text{ (incorrectly called (-) by the test)}}{500 \text{ (\# of people with the disease)}} = 20\% \text{ False (-)}$$

$$\text{Specificity} = \frac{450 \text{ (correctly called (-) by the test)}}{500 \text{ (\# of people with the disease)}} = 90\%$$

$$\frac{50 \text{ (incorrectly called (+) by the test)}}{500 \text{ (\# of people without the disease)}} = 10\% \text{ False (+)}$$

Our hypothetical test has 80% sensitivity and 90% specificity. These are inherent qualities; they do not change, but this fact may be misleading because the sensitivity and specificity of a test does not change the number of people falsely labeled positive or negative with respect to the prevalence of disease in the population tested. For example, if we now apply our hypothetical test to a population with a 10% prevalence, i.e., out of 1,000 people, 100 have the disease; of the 100 with the disease 80% or 80 will be correctly identified as positive (80% sensitivity). Twenty people will be labeled negative but will have the disease. Since the test is 90% specific, 90% of the 900 people without the disease or 810 will be correctly identified as disease free. Ten percent or 90 people will be called positive but will not have the disease.

Now let's compare these figures. In the population with 50% prevalence, 100 people were labeled as negative but had the disease; 50 people were labeled positive but did not have the disease. In the population with 10% prevalence, 20 people were labeled as negative, but had the disease; 90 people were labeled as positive, but did not have the disease.

It seems clear that the diagnostic value (sensitivity and specificity) of a test must be considered in relation to disease prevalence in order to assess its relevance in the applicable situation. The concept which considers the diagnostic value in terms of disease prevalence is called the predictive value. The predictive value, in effect, allows the physician to answer the question: "If a test is positive, how likely is it that the patient has the disease?" or "if the test is negative how likely is it that the patient is disease-free?"

Let's look at the predictive value of a positive test (+) in our sample population and compare:

50% Prevalence

$$\frac{400 \text{ real (+)}}{450 \text{ total (+)*}} = 88\%$$

*(400 real (+) 50 False (+))

10% Prevalence

$$\frac{80 \text{ real (+)}}{170 \text{ total (+)*}} = 47\%$$

*(80 real (+) + 90 False (+))

In a population with 50% prevalence of a disease, there is an 88% probability that a (+) test will indicate the presence of a disease. In a population with 10% prevalence of a disease, there is only a 47% probability that a (+) test indicates the presence of a disease. The higher the prevalence of disease in a population, the greater the predictive value of a positive test. The lower the prevalence of a disease in a population, the more likely a positive test will be a false positive.

Now, the predictive value of a negative test (-):

50% Prevalence

$$\frac{450 \text{ real (-)}}{550 \text{ total (-)}} = 81.8\%$$

10% Prevalence

$$\frac{810 \text{ real (-)}}{830 \text{ total (-)}} = 97.6\%$$

Negative tests in low prevalence populations have greater predictive accuracy than positive tests.

Table 2. — Effect of Prevalence on Predictive Value When Sensitivity and Specificity Equal 99%.

Prevalence	Predictive Value of A Positive Test (%)
0.1	9.0
1.0	50.0
2.0	66.9
5.0	83.9
50.0	99.0

From: R. Galen and R. Gambino, Beyond Normality: The Predictive Value and Efficiency of Medical Diagnoses, John Wiley and Sons, 1975.

Our example uses a test with 80% sensitivity and 90% specificity to demonstrate the principles. Table 2 gives examples of the effect of prevalence on the predictive value of a positive test when specificity and sensitivity are 99%. Take a look at it! Now remember, diabetes has an approximate prevalence of 1,000/100,000 population (i.e., 1%). Assuming 99% specificity and sensitivity for the blood sugar test, the predictive value of a test outside the range of normal is 50%.* That is, chances are equal that

*Using a referent value of 160 mg/dl for the Somogyi-Nelson Test.

the person does or does not have abnormally elevated blood sugar (diabetes mellitus).

Some Conclusions

1. Normal and abnormal cannot be equated with disease free or diseased states.

2. Sensitivity and specificity are determined in a population with a high probability of the disease being tested for. The fact that a test has a high sensitivity tells nothing abouts its ability to predict the probability of absence or presence of disease in an individual.

3. Most textbook and journal information regarding tests comes from the use and application in populations with a high probability of the disease tested for. The usefulness of information derived from high prevalence populations (e.g., hospitalized patients) as applied to low prevalence populations (e.g., patients who come to general practice offices) is questionable.

4. Predictive value is dependent on prevalence of the disease in the population tested. Before a biomedical procedure is applied to a population of patients there must be an understanding of the probability of the problem in the population in order to appropriately assess the outcome of the procedure. A high prevalence population can be created if tests are applied only to people with a likelihood of having the problem. (The probability of an elevated bilirubin reflecting a disease process is high in populations of patients who have nausea, tiredness, and brown urine history.)

There is no value in random application of laboratory studies. Nothing can come of this approach that would offset the potential psychological, economic and physical hardships imposed on patients when these studies are applied and assessed without regard to purposes or without respect for limitations. A physician who views laboratory tests merely as another inexact method for patient evaluation can enhance the usefullness of tests in problem-solving and thereby diminish their harmful potential.

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Posttransfusion Hepatitis in Florida

Paul J. Schmidt, M.D.

Abstract: The risk to patients of posttransfusion hepatitis from blood collected in Florida from voluntary donors from 1975 through the first third of 1979 was 0.12 per thousand transfusions. Data on over a million transfusions exclusive of the Miami area show an attack rate which was parallel to, or less than, that of the rest of the United States, wherever voluntary blood is used.

The occurrence of posttransfusion hepatitis is a function of the carrier rate in the blood donor population. A complete epidemiologic study for both overt and covert hepatitis requires prospective serial blood samples from a large number of blood donors and all their recipients. These samples then must be stored for six or more months for possible retrospective analysis. As a result, prospective studies are feasible only when done on a small number of research patients transfused under controlled conditions.

Nevertheless, it is possible to make comparative studies of overt hepatitis attack rates when comparable epidemiologic criteria are applied to large differences in infectivity. Such a study was reported recently from one Florida hospital.[1] The purpose of that study was to determine if high risk red cells from paid bleedings were or were not "sterilized" by being frozen and washed. They were not, but as a corollary to that study it was observed that a hepatitis attack rate of 2.1 per thousand transfusions then dropped tenfold to 0.3 per thousand when the donor source was changed from paid to volunteer. Knowledge of that attack rate for one location made us curious about the rate in the rest of Florida. Our goal became the establishment of a true attack rate for posttransfusion hepatitis in Florida.

Methods

All 20 community blood banks in Florida were invited to contribute their hepatitis data for the years 1975 through 1978 and the first four months of 1979. That was the time period used in the index study and our parameters were exactly the same as those of that study:[1]

"Transfusion — induced hepatitis was defined as hepatic dysfunction occurring two weeks to six months after the transfusion of blood or blood products for which no other reasonable explanation could be found to account for abnormal tests of liver function. Almost all cases of hepatitis were overt, and the patients had to be admitted to the hospital for confirmation of the diagnosis and treatment."

Each of these blood banks serves a region from a population center which for reporting purposes was placed in one of the four medical districts established by the Florida Medical Association (FMA). In order to reduce overlap reporting, only hepatitis cases were reported in which all blood transfused was from one source blood bank. It is recognized that a reduction in observed attack rate could result from that approach, but that was preferable to otherwise possible duplication and triplication. The validity of the data was established by comparison with the figures held by the Florida State Epidemiologist.

All the blood banks queried are registered or licensed by the Food and Drug Administration and all those that responded operate under the Standards for Blood Banks and Transfusion Services of the American Association of Blood Banks. No donors are accepted who have a history of hepatitis or who give a positive test for the hepatitis B surface antigen. Under federal regulations (21 USC, 606.170) each bank is required to keep a written record of each report of adverse reaction to transfusion. Section J3.200 of the Standards of the American Association of Blood Banks requires them to investigate all possible cases of posttransfusion hepatitis and to keep records which make it possible to evaluate the incidence in blood that they supply. Hospitals which they supply are bound to report all suspect such cases to them. Their records are inspected at least annually by

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both agencies.

Therefore, we received data that had been collected regularly in a standard and uniform fashion and that permitted of a retrospective analysis.

Results

Replies were received from 16 of the 19 community blood banks in FMA Districts A (North Florida), B (Southwest Florida) and C (Southeast Florida). No reply was received from District D which comprises Dade and Monroe Counties, including the city of Miami. All respondents recruit replacement blood donors. None have had paid donors since 1976.

The data on over a million transfusions of blood, red cells, platelets and plasma were provided and are given in Table 1. The case numbers were compared to the data on file with the Florida Department of Health and Rehabilitative Services (HRS). According to a letter from R. A. Gunn, M.D., State Epidemiologist, (November 1979), their data relate only to 1979 when their reporting category of "Hepatitis Associated with Blood and Blood Products" was begun and are given by HRS District related to the patient's location. Although our reports were from all HRS Districts except District XI, which is identical with FMA District D, i.e., Dade and Monroe Counties, we would not expect identity of data. That is because our reports were by locations of the blood banks which might regularly supply blood into a neighboring District where the patient might be transfused. Any cases caused by blood fractions, such as the high risk commercial clotting factors, none of which are made in Florida, also should appear in the HRS data but not in our data. Also their data would include patients who received blood from sources other than our 16 reporting banks. Nevertheless our data collection was more thorough than theirs, since we captured 27 cases in HRS Districts I through X in the first four months of 1979, as compared to their 24.

The attack rate was even lower than the 0.3 per thousand accepted in the index report.[1] However, inspection of that index data shows that their optimum attack rate was based on only sparse data, i.e., one case of hepatitis and 3,116 transfusions.

A search of the hepatitis literature showed that only a few parallel large area studies with large data pools are available. However, some comparisons were possible.

The College of American Pathologists (CAP) and the American Association of Blood Banks conduct a joint national voluntary Viral Hepatitis Survey. Their reporting of data on posttransfusion cases began in July 1978, but before December 1978 the reports were issued on relatively small numbers. For July to September 1978, the first report, the rate was 0.88 on 46,952 transfusions of blood and components; October to December 1978, 0.80 for 45,761 transfusions. Their first large numbers, on 250,645 transfusions, coincided with the last period of our study, December 1978 to March 1979. For that period, in which Florida had an attack rate of 0.20 per thousand transfusions, the CAP reported the national data for 38 community blood banks which had 68 cases of posttransfusion hepatitis for an attack rate of 0.27 (Viral Hepatitis Survey, Chicago, College of American Pathologists, 1979, Set W-A.). Of course some of the Florida data would have been included in the national totals, but at a maximum it could be providing less than 25% of the national data. Since the Florida rate was less than the national rate, it follows that the Florida rate must be lower than the average rate for voluntary donor blood transfusion in the rest of the country.

A report was published in 1979 on posttransfusion hepatitis in New Jersey.[2] It includes only data to 1976. That state has a sophisticated reporting system in operation since 1967. At that time, it was found that of every 100 patients with overt posttransfusion hepatitis, only 75 were hospitalized. Of those 75, only 50 were discovered by hospital records search. Therefore the estimate of total cases of overt posttransfusion hepatitis in

Table 1. — Posttransfusion Hepatitis in Florida Medical Districts.

		Transfusions			Cases			Incidence Per 1000 Transfusions			
	District	A	B	C	A	B	C	A	B	C	Total
1975		74,710	66,674	60,518	19	4	9	0.25	0.06	0.15	0.16
1976		84,326	84,336	76,166	16	6	4	0.19	0.07	0.05	0.11
1977		86,023	94,651	93,407	8	13	8	0.09	0.14	0.09	0.11
1978		94,209	106,598	104,548	9	15	8	0.10	0.14	0.08	0.10
1979	(1st 4 mo.)	31,104	45,771	43,455	7	10	6	0.23	0.22	0.14	0.19
	Total		1,146,496			142					0.12

Table 2. — Posttransfusion Hepatitis: New Jersey vs Florida.*

	Transfusions		% Commercial Blood		Estimated Incidence+ Per 1000 Transfusions	
	NJ	Fla	NJ	Fla	NJ	Fla
1975	201,676	201,902	1.3	1.6	0.38	0.32
1976	213,941	244,828	0.1	0.1	0.38	0.21

* Florida community blood banks exclusive of Dade and Monroe Counties.

\+ Known hospitalized cases times two (see text).

New Jersey could be obtained by taking the number for reported hospitalized cases and multiplying by two.

Although we do not know that Florida hospital data suffer from the same deficiencies, we applied the same correction factors to our raw hospital data as was done in New Jersey for the purpose of comparison. The parallel interpretation is given in Table 2. Again the Florida data show more favorable attack rates.

Discussion

The risk of posttransfusion hepatitis in a large region, such as a single state, can be obtained by a study of the region's blood-service complex and of the cases of overt, recognized posttransfusion hepatitis that can be identified.[2] We have made such an assessment of the state of Florida (exclusive of the Miami area) by obtaining data on over a million transfusions.

Florida is known to have half again as many total cases of hepatitis (the sum of both posttransfusion plus nontransfusion associated disease) as the national average. The 1976 case rate per 100,000 Floridians was 37.2 as compared to the national rate of 26.0.[3] Nevertheless, the Florida blood donor population transmitted posttransfusion hepatitis at less than the national rate.

The necessity for large pool data is evident from fluctuations as much as four-fold (Table 1) for posttransfusion hepatitis attack rates in one year between adjacent districts. That is a result of the relative rarity of the disease in an all-voluntary blood donor system. When we pool for the whole state except the Miami area, which data were not available to us, we were dealing with more than 200,000 transfusions per year and relatively stable attack rates.

The fact that the Florida rate for the first four months of 1979 was almost twice that for any of the preceding three years may represent the abbreviated data base of only 120,000 transfusions. That is more likely than a prediction of a continued upsurge in posttransfusion hepatitis. The CAP data for the second three months of 1979 show a national figure of 0.25 per thousand transfusions as compared to 0.27 for the first three month period corresponding to ours. In any case that current Florida rate was still lower than the comparable national rate.

The comparisons made between New Jersey and Florida for 1975 and 1976 relate two states which are comparable in population size. At that time, the population of New Jersey was about 7,300,000 and Florida was 8,300,000. If we subtract the 1,500,000 people living in the Miami metropolitan area, on whom we did not receive data, the figures are even closer. In Table 2 we have shown a slightly higher transfusion load for Florida than New Jersey, which may represent a use of blood components in addition to whole blood, and also a greater average age of the Florida population. In any case, Florida attack rates were consistently below those of New Jersey.

Acknowledgments

All the blood banks that contributed their data to this study are recognized for their interest in the control of posttransfusion hepatitis.

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Surgical Management of Main Left Coronary Artery Disease

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Abstract: Sixty-five patients with ≥70% stenosis of the left main coronary artery were treated surgically between January 1974 and December 1979. The group consisted of 50 men and 15 women with a mean age of 62.5 years. All patients were symptomatic with angina pectoris and 54 patients (83%) had unstable angina. Twenty-three patients (41%) had electrocardiographic evidence of old myocardial infarction and only five (7%) had a normal resting ECG. Preoperative exercise testing was done in 20 of 65 patients. The stress test was positive in all patients, 15 (75%) had >2mm ST depression. The ejection fraction ranged from 89% to 30% with a mean of 64%. Ninety two percent (60/65) had significant right coronary artery disease. The intra-aortic balloon pump was inserted prior to anesthesia in four patients (6%) and was required in two additional patients postoperatively. An average of three grafts per patient were inserted. There were three (4.6%) postoperative myocardial infarctions and two (3.1%) deaths. During the follow-up period which comprised of 105 patient years there was one myocardial infarction and one death. These data indicate that successful surgical treatment of left main coronary artery disease can be achieved with low mortality and that routine preoperative insertion of the intra-aortic balloon pump is unnecessary.

Patients with severe steonosis of the left main coronary artery are in jeopardy of massive myocardial infarction and death.[1-6] Debate still exists as to the efficacy of coronary bypass surgery in prolonging life for most forms of coronary artery disease; however, there is increasing evidence that surgical treatment for left main coronary artery disease improves survival.[7-13] There also has been marked decrease in operative mortality and morbidity due to improved surgical technique and more effective methods of myocardial protection.[1-15] The reduced operative mortality and improved prognosis following surgery make identification and surgical therapy of this high risk subgroup essential.[1-13] We have reviewed our six years experience with this important form of

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Table 1. — Clinical Data.

Sex		
Male	=	50
Female	=	15
Total		65
Age		
Average	=	62.5 years
Race		
Caucasian		100%
Angina		
Chronic stable angina	=	11
Unstable, progressive	=	54 (84%)
		65

Table 2. — ECG and Stress Test.

	#	%
Normal	5	7.7%
Ischemic changes	18	27.7%
Old myocardial infarction	8	12.3%
Conduction abnormality	5	7.7%
Ischemic changes and old myocardial infarction	12	18.5%
Ischemic changes and conduction abnormality	11	16.9%
Old myocardial infarction and conduction abnormality	3	4.6%
Ischemic changes, conduction abnormality, and old myocardial infarction	3	4.6%

coronary atherosclerosis with emphasis on clinical presentation, perioperative management, and surgical results.

Methods and Materials

Sixty-five patients with ≥70% stenosis of the left main coronary artery were treated surgically between January 1974 and December 1979. The group consisted of 50 men and 15 women with an average age of 62.5 years (Table 1). All patients were symptomatic with angina pectoris and 54 patients (84%) had unstable angina. Resting ECGs were analyzed for all patients. Only five patients (7.7%) had normal tracings, the remainder had either a conduction abnormality (five patients) or old myocardial infarction alone (eight patients) or with associated ischemic changes (18 patients) (Table 2). Data on preoperative exercise stress testing were available in 20 of 65 patients. The test was positive in all 20 patients and 15 patients (75%) were reported to have significant positivity with >2mm ST depression in the first or second stage of testing (Table 3). Coronary angiography confirmed ≥70% narrowing of main left coronary arteries in all patients. Sixty patients (92%) had significant right coronary artery disease. The ejection fraction ranged from 30% to 89% and the average was 64%. The left ventricular end diastolic pressure was less than 12mm Hg in 23 (35.4%) patients and >12mm Hg in 42 patients (64.6%) (Table 4). All patients underwent coronary artery bypass surgery with cardioplegic myocardial arrest and continuous aortic clamping except for patients operated on prior to 1976. An average of three grafts per patients were inserted:

Table 3. — Stress Testing Performed in 20/65 Patients.

Positive	— 20 patients	= 100%
> 2mm. ST depression in early stages.	— 15 patients	= 75%

Table 4. — Hemodynamics and Angiography.

All patients had ≥70% narrowing of main left coronary artery.

60/65 (92%) had significant right coronary disease.

Ejection fraction: Lowest 30%
Highest 89%
Mean 64%

Left ventricular end-diastolic pressure:

≤12 mm Hg = 23 = 35.4%
>12 mm Hg = 42 = 64.6%
65 = 100%

The mean ischemic time was 45.4 minutes and the mean perfusion time 103 minutes (Table 5). Beginning in 1977 the left internal mammary artery was used to bypass the left anterior descending coronary artery. The intra-aortic balloon pump was used in four (6%) patients prior to induction of anesthesia and was required in two additional patients postoperatively (Table 5). The balloon was used preoperatively in these four patients because of continued ischemic pains despite optimum medical therapy and in two patients postoperatively for low output syndrome.

Results and Follow-up

There were three (4.6%) perioperative myocardial infarctions and two (3.1%) hospital deaths (Table 6). One death occurred in an 81-year-old male who suffered postoperative hemorrhagic pancreatitis and myocardial infarction. The other patient had thrombocytosis of unknown etiology (platelet count >1 million) and suffered a global infarction with patent grafts. During the follow-up period which comprised 105 patient years there was one nonfatal myocardial infarction and one late death. The late myocardial infarction occurred in a patient who had proven occluded vein graft to the left anterior de-

Table 5. — Operative Data.

All 65 patients underwent bypass surgery.

Average — 3 grafts per patient. 2 grafts = 9
3 grafts = 43
4+ = 13

Preoperative balloon insertion = 4 (6%)
Postoperative balloon insertion = 2 (3%)
Mean aortic cross clamp time = 45.4 minutes
Mean perfusion time = 103 minutes

Table 6.

Postoperative myocardial infarction	3	= 4.6%
Postoperative death	2	= 3.1%

1st patient: pancreatitis and myocardial infarction

2nd patient: global infarct secondary to thrombocytosis

scending coronary artery. The single late mortality was a result of inoperable carcinoma of the lung (Table 7). One patient has recurrent chest pains and has two out of three grafts occluded and 61 patients or 93% are angina free.

Comments

Our data and that of others indicate that the possibility of left main coronary artery stenosis should be considered in patients with severe or unstable angina or those with early positive exercise testing.[2,4-8,12,13] Coronary angiography should be performed in such patients to identify this high risk subgroup since there is increasing evidence of improved survival with surgical therapy.[1-15]

The place of the intra-aortic balloon pump in surgical management of these patients is not well defined.[14,15] We have limited its use to a very few selected patients who had continued ischemic chest pains, hypotension with angina or medically intractable ventricular arrhythmias. Continued therapy with coronary vasodilators and beta-blockers in the immediate preoperative period and careful monitoring of blood pressure during anesthesia induction have helped to avoid use of the balloon pump.[15] When required, it has been inserted under local anesthesia prior to induction of general anesthesia and support maintained postoperatively for 24 to 48 hours.

The in-hospital mortality rate of 3.1% compares favorably with other large published series.[1,5-10,14,15] The follow-up period is comprised of 105 patient years and there has been only one late non-fatal myocardial infarction and one late noncardiac death. Our data indicate that successful surgical treatment of left main coronary artery disease can be achieved with low mortality [5-10] and that routine preoperative insertion of the intra-aortic balloon pump is unnecessary.[15]

Table 7. — Follow-up.

Follow-up 105 patient years		
Late death	= 1	(Ca of the lung)
Late MI	= 1	
Proven occluded graft to LAD		
Recurrent angina	= 1	(2 out of 3 grafts occluded)
Symptom free	= 61	patients or 93%

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A Study of Florida's Rural Physicians

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Abstract: The Florida Medical Association distributed a questionnaire to all its members but only those practicing in a rural area were requested to respond; 248 did. This report summarizes aspects of the practices of 183 based upon their attitudes and estimates of various features. Most are engaged in family or general practice. There appears to be a high degree of stability among them regarding future professional plans. All indicate that the current physician manpower need for rural Florida is principally family physicians. Internists and pediatricians are needed also. An average work week probably does not exceed that of urban practitioners but there is wide variation in scheduled work time and after hours call time.

The Florida Medical Association mailed a questionnaire to its members in late 1978 requesting that all physicians currently practicing in a rural area or who had practiced in such an area during the last five years complete and return the questionnaire. The survey was conducted by the Association's Committee on Rural Health to delineate as clearly as possible those factors of medical practice in rural Florida which would be identified by rural practitioners.

Since there is no widely accepted definition of rural versus urban, the Committee decided to send the questionnaire to all members of the Association as an addendum to the newsletter. The questionnaire was plainly identified for rural physicians. The members of the Committee believed that it was unlikely that physicians practicing in populous towns or cities would characterize their practice as rural. We believed that the term may even have pejorative connotations which would limit the number of physicians who would choose to identify themselves as "rural" practitioners.

Results

The survey yielded responses from 248 physicians; however, 65% indicated that they had not practiced in a rural area during the past five years. Only 183 stated they were in rural practice or had left rural practice within the past five years. Their mean age was 47 and the mean number of years they had practiced was 16.

An official Florida map based upon the 1970 census was used to determine the population size of communi-

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Table 1. — Population of Office Location Generated from Official State Map.

Size	Number	Percent	Cumulative Percent
1,000 or less	16	9.2	9.2
1,000 - 2,500	22	12.7	22.0
2,500 - 5,000	34	19.7	41.6
5,000 - 10,000	39	22.5	64.2
10,000 - 25,000	44	25.4	89.6
25,000 - 50,000	10	5.8	95.4
100,000 and over	8	4.7	100.0
TOTAL	173	100.0	

ties identified by respondents as the sites of their office locations. No doubt most communities have increased in size since 1970 but this method was believed to yield a more reliable index of size than that provided by the physicians' own estimate of their "practice site population." Of 173 physicians who provided addresses, 64.2% practice in towns of 10,000 or less and 89.6% in towns of 25,000 or less (Table 1). When physicians defined their practice sites, 72% classified them as rural, 12% as urban, and 6% were unsure whether rural or urban.

Rural Practice Site Population

The respondents' estimate of their "rural practice site population" showed that approximately 40% practice in communities under 10,000, and 72% in communities less than 25,000 (Table 2). From the marginal comments, it was apparent that some doctors reported the population of the town they practiced in and still others the population of their practice service area. For this reason the procedure previously described was used as the measure of population size.

Only 18 respondents gave useful information on reasons for leaving rural practice. Of these, eight left because of problems, e.g., "poor medical facilities, poor financial rewards, need urban population density to practice specialty." One reported leaving because of a lack of cosmopolitan features such as cultural opportunities and shopping centers.

In general, the respondents indicated that they will maintain stable practices in the coming years. Only 16% plan to change their office facilities; 11.5% are planning to relocate their practice, 77.2% within the same county. A majority (67.9%) do not plan to reduce their practice for at least 10 years; 13.5% never plan to reduce their practice (Table 3). An even greater majority (83.4%) will wait at least 10 years to retire, with 22.6% claiming they will never retire (Table 4). There is a slight tendency for practitioners in smaller communities to plan to reduce their practice earlier and a tendency exists for those in the even smaller rural areas to plan retiring sooner.

More than half the respondents were in general or family practice; 56.8% checked general/family or indicated their specialty as family practice. This finding contrasts sharply with the national physician population in which only 20% are in general practice.

Some 51% of the respondents indicated that they practice a specialty. Table 5 presents a breakdown of the specialties reported. As expected, there was a direct relationship with the population density of office location.

Five physicians who stated they were general or family practitioners also indicated that they practice surgery. In addition many who indicated their specialty

Table 2. — Rural Practice Site Population M.D.'s Estimate

Size	Number	Percent	Cumulative Percent
Under 2,500	12	6.8	6.8
Under 5,000	16	9.0	15.8
Under 10,000	42	23.7	39.5
Under 25,000	58	32.8	72.3
Under 50,000	49	27.7	100.0
TOTAL	177	100.0	

Table 3. — Physicians' Plans to Reduce Level of Practice.

When Reduction is Planned	Number	Percent	Cumulative Percent
1 - 5 years	21	12.3	12.3
6 - 10 years	34	19.9	32.2
11 - 20 years	51	29.8	62.0
More than 20 years	42	24.6	86.5
Never	23	13.5	100.0
TOTAL	171	100.0	

Table 4. — When Physicians Expect to Retire.

Will retire in	Number	Percent	Cumulative Percent
1 - 5 years	14	8.3	8.3
6 - 10 years	14	8.3	16.7
11 - 20 years	51	30.4	47.0
More than 20 years	51	30.4	77.4
Never	38	22.6	100.0
TOTAL	168	100.0	

Table 5. — Type of Specialty Practiced.

Specialty	Number	Percent
General/family practice	104	56.8
Surgery	18	9.8
Internal medicine	14	7.6
Pediatrics	10	5.5
Radiology	9	4.9
Obstetrics-gynecology	8	4.3
All other specialties (11)	34	18.5
TOTAL	197*	107.4*

as internal medicine also noted cardiology as a subspecialty. Thus the percentage breakdown of those who stated that they were general or family practitioners, specialists, and subspecialists were obscured somewhat.

Some 61.7% of the respondents are solo practitioners. Among the 28.9% who practice in a group, the mean number of practitioners per group is 2.8. Of the 32 physicians who indicated the type of group practice in which they participate, 75% practice in a single specialty group. Finally, very few physicians reported working in less traditional settings. Only three stated they were emergency room physicians and 14 others hold government positions. Twelve of the government physicians are engaged in primary care and the other two are pathologists.

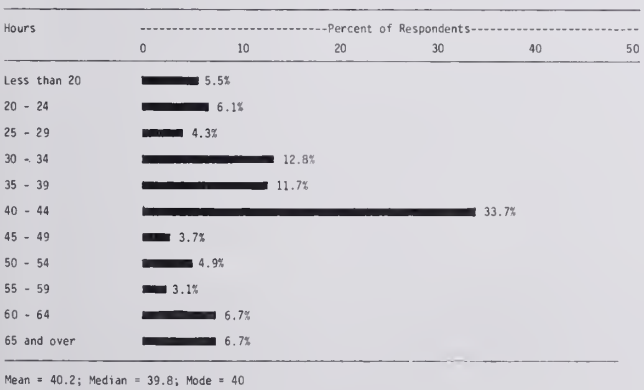
Practice Patterns

A question concerning the physicians' schedule generated two variables. The first was the number of hours worked per week. The standard 40-hour week was the mean response. This statistic apparently represents an accurate measure of central tendency as the median and mode were almost identical to the mean (Fig. 1).

There is reason to believe that most physicians reported only their office hours; however, some may have included hospital rounds. Those who reported hours of practice outside the traditional nine to five work day were also tallied; 14 reported Saturday hours, seven evening hours, and three both Saturday and evening hours. This measure does not indicate if the unusual hours of practice are exclusively devoted to the office or include hospital rounds.

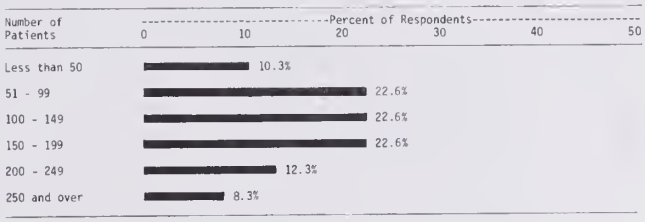
The average number of patients seen per week range from "none," a response which probably came from pathologists and those in exclusively administrative positions, to as many as 450 (Fig. 2). One physician who sees 350 patients per week reported using a physician assistant. It is possible that his even more prolific colleagues were also using physician extenders. There exists no relationship between number of hours worked per week or number of patients seen per week and the population density of the community in which the respondents practice. A very small number of patients are generated by referral. The majority, 77%, reported that less than one fourth of their practice resulted from referrals and 30% reported that none of their practice was by referral.

Figure 1. Number of hours of practice per week.



Mean = 40.2; Median = 39.8; Mode = 40

Figure 2. Number of patients seen per week.



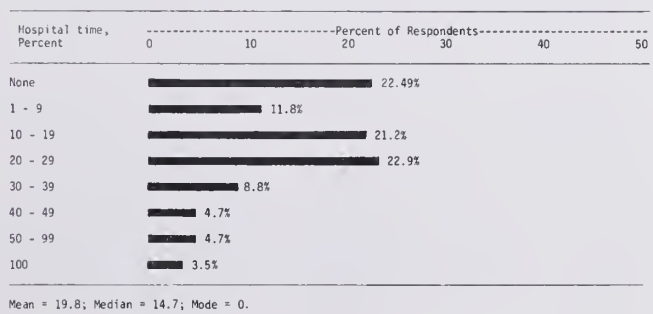
Mean = 132.5; Median = 124.4; Mode = 150. (based on continuous data).

A question concerning time spent on delivering preventive care omitted the choice of 0-24% of time. Despite this, only 18% indicated no preventive medicine activities and two thirds indicated 24-49% of time spent in preventive medicine, but 52% believed that more preventive care should be included in their practice. Finally, 62% felt the need for "more preventive medicine in the country."

When asked the percentage of care delivered in the office, the mean response of these physicians was 63.6%. This average is skewed by those few reporting that they do not have an office practice, e.g., radiologists, pathologists, and reported 0% of their time in the office. The median of this same distribution indicates that 75% of practice in the office is probably a more accurate figure. Approximately one fifth of the respondents' time is spent in hospital care (Fig. 3). Only 7.9% of the physicians' time is spent in the operating or delivery room. Most (73%) do not make house calls, while an additional 16% spend only 1% of their time on house calls. A final 10% of physicians spend between 2% and 10% of their time on home visits. Population density was found to be inversely related to house calls. Finally, only an average of 1.3% of the respondents' time is spent delivering care in other sites such as nursing homes.

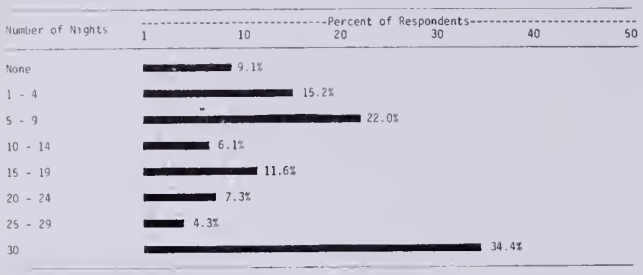
The majority of responding physicians (89%) require appointments and are accepting new patients (98%).

Figure 3. Percent of time spent in hospital care.



Mean = 19.8; Median = 14.7; Mode = 0.

Figure 4. Number of nights per month on call.



Mean = 14.4; Median = 10.5; Mode = 30

More than half (54%) accept Medicaid patients and 82% Medicare patients. Many indicated that they do not accept direct payment by Medicare.

An interesting distribution of time spent on administrative tasks is observed, the mean amount being 11%. This distribution had at least two primary modes, of 25% and 26% of respondents respectively reporting 5% and 10% of their time. In addition, 16% report that they spend 1-2% of their time at administrative tasks. A few reported 50%, 80%, and even 90%. These physicians appear to have set aside their clinical role in favor of nearly full-time administration.

The mean number of nights on call per month is 14. The outstanding mode is 30 nights a month (Fig. 4). In addition, close to 10% are never on call. An examination of the continuous data shows that there are groupings of doctors who are never on call, or who are on call seven or eight times a month, or who are on call one half the month. The largest group, however, report being on call every night during a typical month.

The number of weekends on call per month is trimodal. Only 11% are never on call. About 28% report being on call in each of the following categories: once a month, twice a month, or all weekends of a month.

The largest percentage of physicians (35.2%) do not share call with any colleagues, 22% share call with one colleague, and 25% with two or three colleagues. The data show that just over half the respondents are satisfied with after hours coverage. The level of satisfaction was not related to population density of the office location.

Additional in-depth study of the question of after hours coverage produced several findings. First, as expected, strong negative correlations exist between the number of nights and weekends on call and satisfaction with on call schedule. Second, satisfaction with schedule is strongly related to the number of physicians sharing call. Third, a positive relationship was found between willingness to use physician extenders and dissatisfaction with the call schedule. Fourth, as might be expected, those in solo practice are not happy with their schedule while those in group practice are more likely to be satisfied.. Fifth, agreement with the concept that additional specialists are needed in the physician's geographic area is directly related to schedule dissatisfaction, while agreement that additional primary care physicians are needed in the area is unrelated to schedule satisfaction. Finally, schedule satisfaction is positively related to income satisfaction.

Very few physicians knew of colleagues who planned to locate in their county. Eighty two percent did not know of any other doctors moving into their home county while the other 18% knew of three or fewer physicians planning to move to their counties.

The data on the respondent's assessment of the need for additional physicians in the area are summarized in Table 6. The percentage indicating the need for specialty areas is reported rather than the total number of specialists because of the various responses to the question.

The data on the rural physicians' willingness to utilize physician extenders yielded a number of findings. Only 30.5% of the respondents would consider utilizing physician assistants while 35.2% would consider utilizing nurse practitioners. There is a small but statistically significant relationship between willingness to use physician extenders and dissatisfaction with call schedule but no relationship with income was found. Thus, physician extenders may be valued in terms of their suitability to extend the doctor's time but not as a means of increasing income. Physicians who reported a need for more preventive medicine in their practice are also more likely to consider use of physician extenders. A significant relationship between willingness to use physician extenders and acceptance of Medicaid was also found. Finally, there exists a positive relationship between acceptance of physician extenders and general dissatisfaction with the health care delivery system.

Table 6. — Need for Additional Physicians.

Type of specialist needed	Percent of respondents indicating need
1. General/family practice	52.9
2. Internal medicine	35.5
3. Pediatrics	30.5
4. Orthopaedics	27.5
5. Obstetrics-gynecology	24.6
6. Psychiatry	24.1
7. Surgery	23.9
8. Urology	23.9
9. Anesthesiology	17.6
10. Ophthalmology	12.7

Table 7.– Evaluation of Existing Care System: Median Scores.

Characteristic of county's health care system	Median score
1. Utilization of existing resources	3.9
2. Provision for the medically indigent	3.1
3. Provision for acute care	4.3
4. Provision for preventive care	3.0
5. Provision for 24-hour emergency	4.6
6. Provision for follow-up care for emergency room patients	4.0
7. Provision for 24-hour pharmacy	2.9
8. Guarantee of accessibility of health care	3.8
9. Resolution of patient — M.D. conflicts	3.5
10. Adequacy of third party coverage	2.5

(5 = highest satisfaction)

Health Care System

All respondents were asked to evaluate their county's existing health care system by ranking several characteristics on a scale of "one to five." Table 7 summarizes the results.

From these items a general index of satisfaction with the local health care system is generated. This index was computed by adding the sources reported in the "evaluation of existing health care systems" section of the survey. The index scores range from a low satisfaction score of 10 to a high of 49. The distribution appeared to be normal with the mean, median, and mode all hovering around 35. These scores were correlated with other theoretically interesting variables.

There is a slight association between increasing population density of the practice site and decreasing satisfaction with the health care system. Those in the nontraditional government positions indicate slightly less satisfaction with the system. Physicians indicating the need for more preventive care in their practice are significantly more dissatisfied with the health care system than the average respondent, as are those spending more time on administrative tasks and, thus, away from clinical work. Satisfaction with schedule and income are both significantly related to general satisfaction with the system. Finally, physicians willing to use physician extenders are more dissatisfied with the traditional health care system than those unwilling to use physician extenders.

Most respondents (67.1%) are satisfied with their income. No relationship exists between population density and income satisfaction. A positive relationship between income satisfaction and group practice was found. Those dissatisifed with their incomes are also more likely to accept Medicaid patients. Finally, those most satified with the incomes are also most satisifed with the health care delivery system.

A total of 63% of those responding indicated they would attend a rural practice conference if the Florida Medical Association should sponsor such an event.

In general, the responding physicians listed more advantages to rural practice than disadvantages. This is not surprising because the sample is comprised mostly of physicians who have chosen to remain in rural practice. The three most often reported advantages in order of magnitude were: avoiding problems associated with urban population density; knowing the patient and the patient's family, and enjoying the idyllic country setting. The three most often reported disadvantages were: isolation from the medical community; lack of urban amenities such as goods, services, and cultural events, and poor third party coverage.

Discussion

It is noteworthy that these rural physicians are approximately at mid-career (mean age 47) and that most of them intend to continue in rural practice. Furthermore, most do not intend to reduce significantly the volume of their practice in the near future. It is noteworthy that the mean practice time of 18 years is reasonable assurance that the respondents are in a stable situation in terms of hours of work, income satisfaction, hospital practice, and estimates of medical manpower needs in their communities.

The large percentage of family physicians and general practitioners in this survey is not surprising since one would expect generalists to meet best the broad spectrum of medical needs in rural communities. The respondents' estimates of additional specialty needs are for more generalists (52.9%) and two "primary care" specialties, internal medicine (35.5%) and pediatrics (30.3%).

Solo practice is still the dominant mode in rural Florida (61.7%), but two thirds of the practitioners share night and weekend calls with other physicians. One third report being on call 30 nights a month, and this clearly undesirable feature of rural practice is reflected in the general level of satisfaction with practice.

A recent national survey revealed that rural physicians worked longer hours than their urban colleagues. For this reason we were surprised that the average work week reported was 40 hours, even though 25% of the respondents report work weeks of 45 to 65 plus hours. These figures may reflect the fact that almost one fourth of the respondents spend no time in hospital practice;

hence they devote their total work time to ambulatory care in the office. Two thirds of the physicians see 100 or more patients per week in the office. The highest estimate was 450. It is clear that rural practice is predominantly office practice although one fifth of the respondents are exclusively office based.

Availability of a hospital is widely recognized as a determinant in attracting and keeping doctors in rural areas. Given the structure of current training programs in family medicine, this is unlikely to change. Young family physicians, with rare exception, will not select a practice site where all hospitalized patients must be referred. Our impression is that the reason for this is not economic but part of the individual's self-image as a complete physician who can best meet his patient's needs in both office and hospital settings. One third of the doctors in this sample spend one to 19 hours per week in the hospital. It is problematic, to say the least, that small periods of time spent in the hospital are economically as rewarding as equivalent time spent in the office, particularly when this time is not spent doing surgical procedures.

Over half the respondents accept Medicaid patients. This contrasts with a recent study of a smaller sample of Florida family physicians in both rural and urban locations in which 17% regularly accept Medicaid patients.[1] These data suggest that the rural physician accepts Medicaid because there is no other payment resource for the patient, even though reimbursement is inadequate and payment is usually delayed.

The obvious concern for and commitment to the preventive medicine needs in these practices is a major finding in this study. Although no further definition of this concern was sought, the finding suggests that rural physicians are acutely aware of "prevention" as a concept. Demonstration of more effective preventive measures, particularly for chronic diseases, which could be implemented in rural areas would apparently find ready acceptance among these physicians. Lewis Thomas has recently spoken to the dearth of knowledge about effective prevention.[2]

Finally, these physicians view health care in their geographic areas as generally adequate but far from perfect. Two areas which rank poorly are inadequacies of third party coverage and 24-hour pharmacy services. The former problem is nationwide. A major deficiency in rural health care is absent or inequitable third party payment schemes. The latter simply means that in the most rural areas of Florida the health care team at night consists of the physician and the patient's family — no pharmacist, no nurse, no emergency room, no hospital.

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2. Thomas, L.: Lives of a Cell, Bantam Press, 1975, pp. 95-101.

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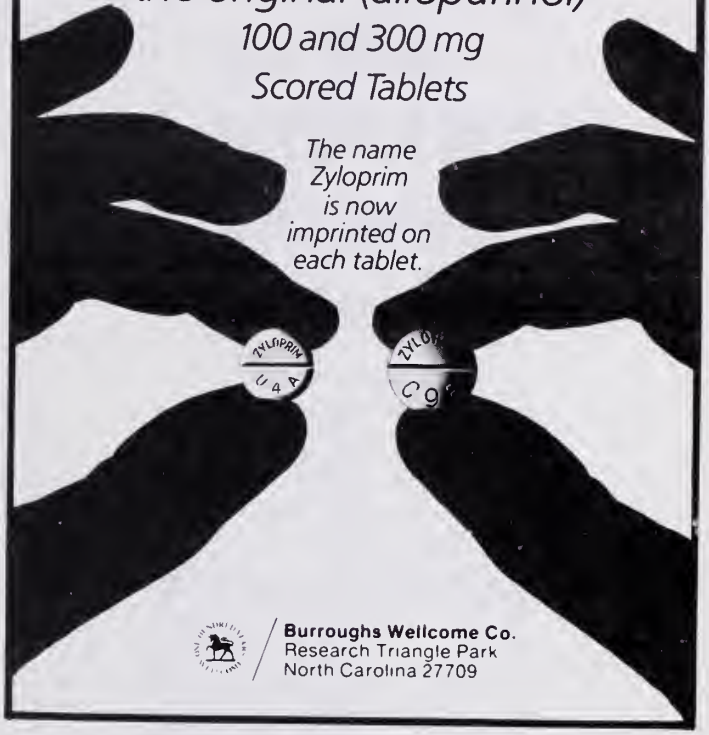
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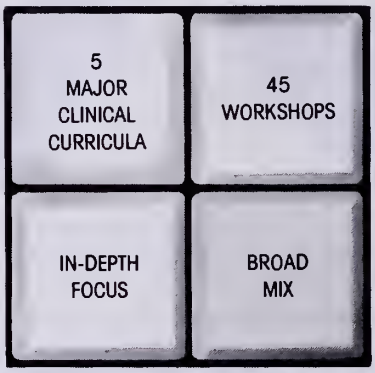
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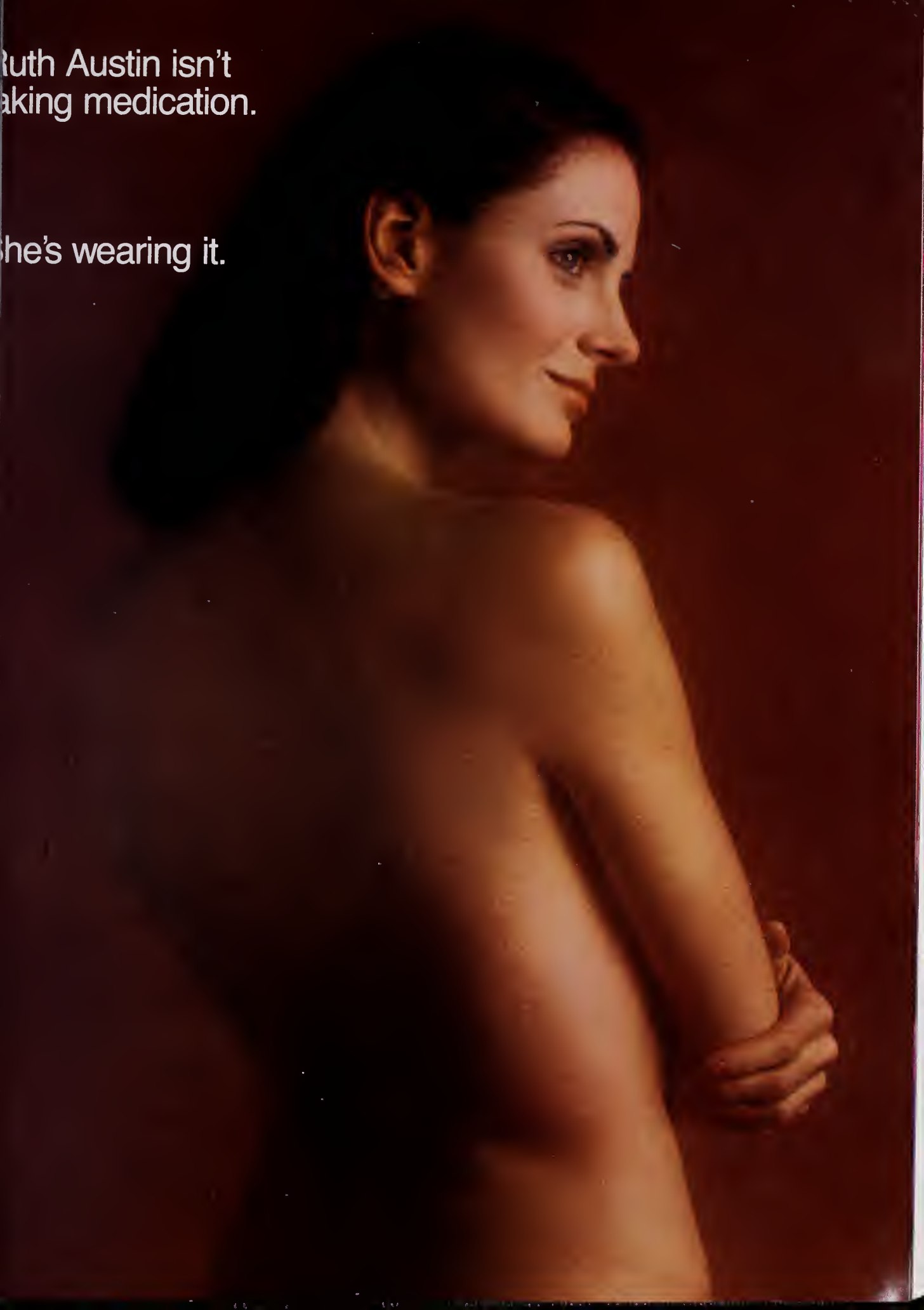
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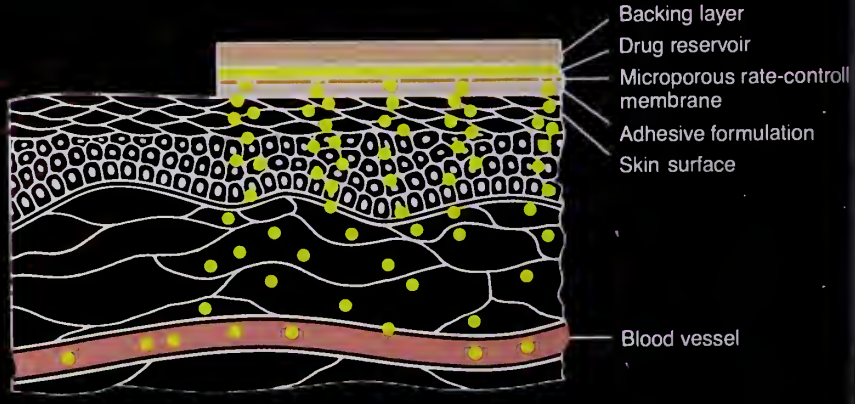
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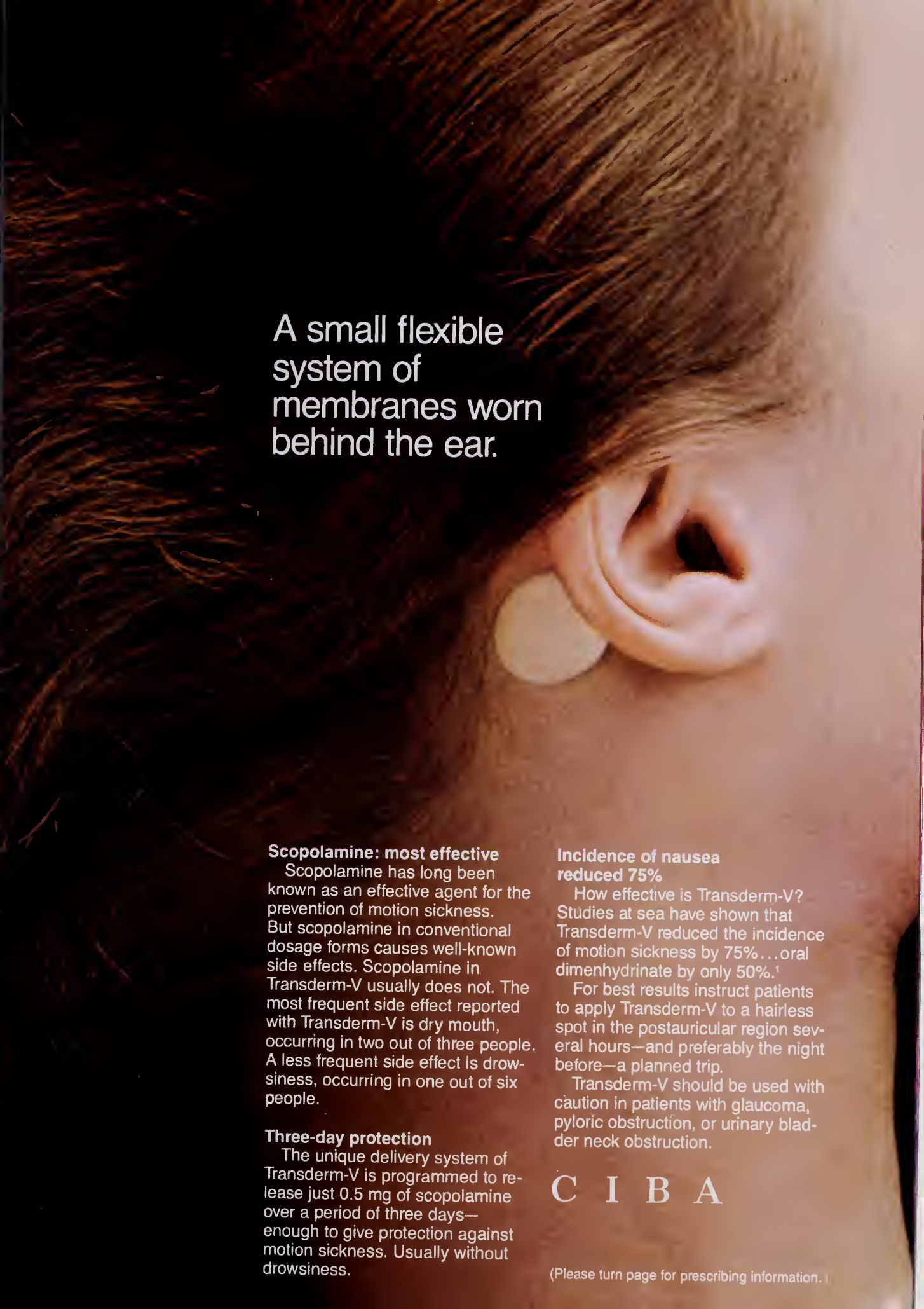
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Transdermal
Therapeutic
System for
motion sickness



Schematic drawing showing cross section of skin surface with Transderm-V in place and delivery of scopolamine to blood vessels.



A small flexible system of membranes worn behind the ear.

Scopolamine: most effective

Scopolamine has long been known as an effective agent for the prevention of motion sickness. But scopolamine in conventional dosage forms causes well-known side effects. Scopolamine in Transderm-V usually does not. The most frequent side effect reported with Transderm-V is dry mouth, occurring in two out of three people. A less frequent side effect is drowsiness, occurring in one out of six people.

Three-day protection

The unique delivery system of Transderm-V is programmed to release just 0.5 mg of scopolamine over a period of three days—enough to give protection against motion sickness. Usually without drowsiness.

Incidence of nausea reduced 75%

How effective is Transderm-V? Studies at sea have shown that Transderm-V reduced the incidence of motion sickness by 75%...oral dimenhydrinate by only 50%.[1]

For best results instruct patients to apply Transderm-V to a hairless spot in the postauricular region several hours—and preferably the night before—a planned trip.

Transderm-V should be used with caution in patients with glaucoma, pyloric obstruction, or urinary bladder neck obstruction.

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(Please turn page for prescribing information.)

Transderm™-V
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No highs or lows of plasma concentrations

Because transdermal administration eliminates the relatively high concentrations of drug that follow oral and intramuscular administration, the undesirable pharmacologic effects associated with high drug levels are usually avoided. Yet an effective therapeutic dosage is achieved and maintained—for 72 hours.

Reference
1. Price N, Schmitt LG, Shaw JE, Trobough T, McGuire J. Transdermal delivery of scopolamine for prevention of motion-induced nausea at sea. Data on file, ALZA Corporation, California.

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Transderm™-V
(scopolamine)

Transdermal Therapeutic System

Programmed delivery *in vivo* of 0.5 mg scopolamine over 3 days

Description Transderm™-V scopolamine system is a circular flat unit designed for continuous release of scopolamine following application to an area of intact skin on the head, behind the ear. Clinical evaluation has demonstrated that the system provides effective antiemetic and antinauseant actions when tested against motion-sickness stimuli in adults.

The Transderm™-V system is a 0.2 mm thick film, with four layers. Proceeding from the visible surface towards the surface attached to the skin, these layers are: 1) a backing layer of aluminized polyester film; 2) a drug reservoir of scopolamine, mineral oil, and polyisobutylene; 3) a microporous polypropylene membrane that controls the rate of delivery of scopolamine from the system to the skin surface; and 4) an adhesive formulation of mineral oil, polyisobutylene, and scopolamine. Prior to use, a protective peel strip of siliconized polyester which covers layer 4 is removed.

The mineral oil (12.4 mg) and polyisobutylene (11.4 mg) inactive components are not released from the system.

Release Rate Concept: Transderm™-V system, 2.5 cm^2 in area, contains 1.5 mg scopolamine. The system is programmed to deliver 0.5 mg scopolamine, at an approximately constant rate to the systemic circulation, over the 3-day lifetime of the system. An initial priming dose of scopolamine released from the adhesive layer of the system, saturates the skin binding sites for scopolamine and rapidly brings the plasma concentration to the required steady state level. The continuous controlled release of scopolamine, that follows from the drug reservoir through the rate controlling membrane, then maintains the plasma level constant.

Clinical Pharmacology The formulation of the Transderm™-V system contains as its sole active agent the drug scopolamine, a belladonna alkaloid with well-known pharmacological properties. The drug has a long history of oral and parenteral use for central anticholinergic activity, including prophylaxis of motion sickness. This formulation provides for a gradual release of scopolamine from an adhesive matrix of mineral oil and polyisobutylene applied to the postauricular skin.

Clinical Results: The Transderm™-V system provides antiemetic protection within several hours following application of the system behind the ear. With the 195 adult subjects of different racial origins who participated in clinical efficacy studies at sea or in a controlled motion environment, there was a 75% reduction in the incidence of motion-induced nausea and vomiting. The Transderm™-V system provided significantly greater protection than that obtained with oral dimenhydrinate.

Indications and Usage The Transderm™-V system is indicated for prevention of nausea and vomiting associated with motion sickness in adults. The system should be applied only to skin in the postauricular area.

Contraindications Transderm™-V system should not be used in patients with known hypersensitivity to scopolamine or any of the components of the adhesive matrix making up the therapeutic system.

Warnings Since drowsiness, disorientation and confusion may occur with the use of scopolamine, patients should be warned of the possibility and cautioned against engaging in activities that require mental alertness, such as driving a motor vehicle or operating dangerous machinery.

Potentially alarming idiosyncratic reactions may occur with ordinary therapeutic doses of scopolamine.

Usage in Children: Children are particularly susceptible to the side effects of belladonna alkaloids. Transderm™-V system should not be used in children because it is not known whether this system will release an amount of scopolamine that could produce serious adverse effects in children.

Precautions Scopolamine should be used with caution in patients with glaucoma, pyloric obstruction, or urinary bladder neck obstruction. Caution should be exercised when administering an antiemetic or antimuscarinic drug to patients suspected of having intestinal obstruction.

Pregnancy: Reproductive studies have been performed in rats and rabbits and have revealed no evidence of impaired fertility or harm to the fetus due to scopolamine administered, with plasma levels in excess of those attained by use of the Transderm™-V system in humans. However, the Transderm™-V system should be used in pregnant women with motion sickness only when clearly needed.

Nursing Mothers: It is not known whether scopolamine is excreted in human milk. As a general rule, nursing should not be undertaken while a patient is on a drug since many drugs are excreted in human milk.

Adverse Reactions The most frequent adverse reaction to the Transderm™-V system is dryness of the mouth. This occurs in about two-thirds of the people. A less frequent adverse reaction is drowsiness, which occurs in less than one-sixth of the people. Transient impairment of eye accommodation is also observed. The following adverse reactions have also been reported on infrequent occasions during use of the Transderm™-V system: disorientation, memory disturbances, restlessness, giddiness, hallucinations and confusion.

Overdosage Overdosage with scopolamine may cause disorientation, memory disturbances, restlessness, giddiness, hallucinations or confusion. Should these symptoms occur, the Transderm™-V system should be immediately removed. Appropriate parasympathomimetic therapy should be initiated if these symptoms are severe.

Dosage and Administration *Adults: Initiation of Therapy:* One Transderm™-V system, programmed to deliver 0.5 mg scopolamine over three days, should be applied to the postauricular skin several hours before the antiemetic effect is required.

Handling: The hands should be washed and dried thoroughly before applying the system on dry skin behind the ear. Upon removal of the system it should be discarded and the hands and application site washed thoroughly to prevent any traces of scopolamine from coming into direct contact with the eyes. A patient brochure is available.

Continuation of Therapy: Should a system become displaced, it should be removed and replaced with a second system on a fresh skin site in the postauricular area. If therapy is required for longer than 72 hours, the first system should be removed and a second system placed on a fresh skin site in the postauricular area.

Children: Children are particularly susceptible to the side effects of belladonna alkaloids. Transderm™-V system should not be used in children because it is not known whether this system will release an amount of scopolamine that could produce serious adverse effects in children.

How Supplied Transderm™-V systems are available in 2-unit blister packs.

Storage and Handling The system should be stored at room temperature.

Caution Federal law prohibits dispensing without prescription.

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Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma, prostatic hypertrophy, benign bladder neck obstruction, hypersensitivity to chlordiazepoxide HCl and/or clidinium Bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl/Roche) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

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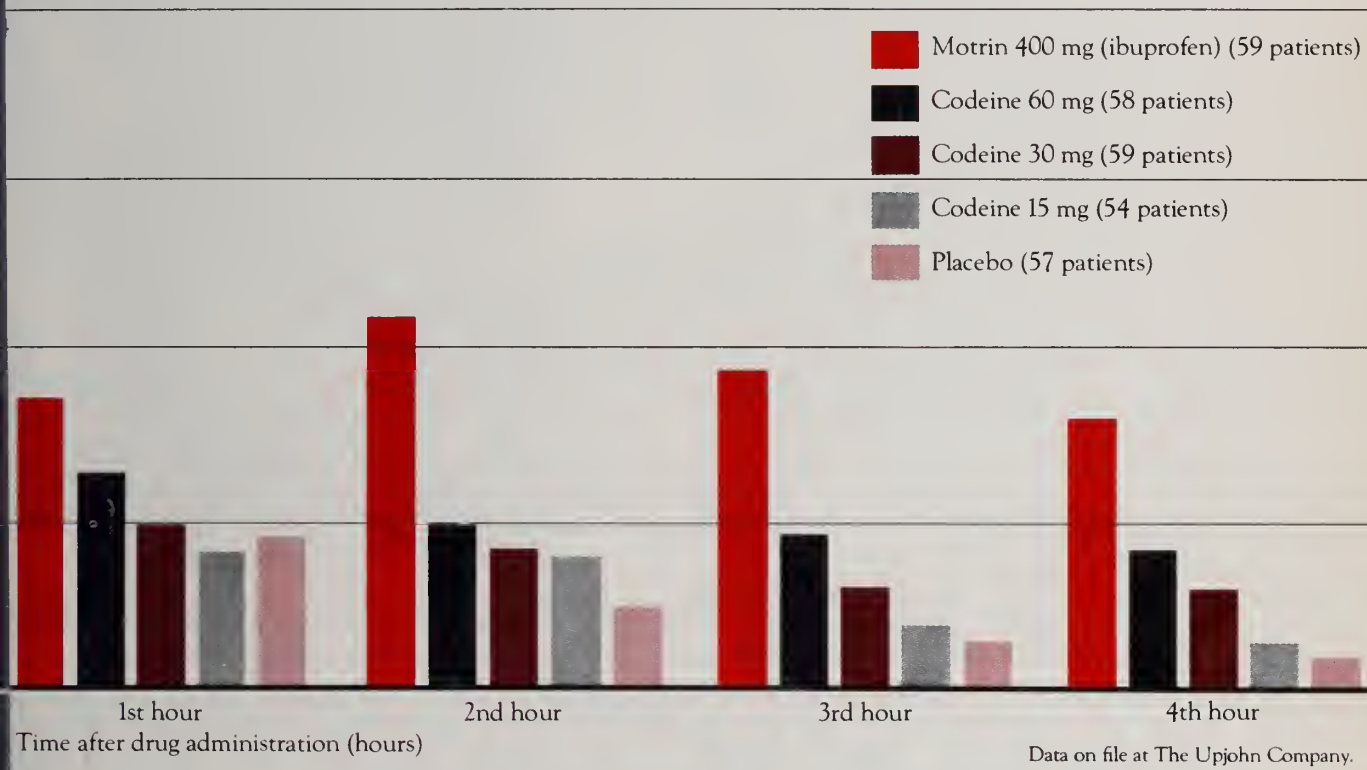
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Motrin® Tablets (ibuprofen, Upjohn)

Indications and Usage: Relief of mild to moderate pain.

Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in long-term management. Safety and efficacy have not been established in Functional Class IV rheumatoid arthritis.

Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS).

Warnings: Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

Drug interactions. *Aspirin* used concomitantly may decrease Motrin blood levels. *Coumarin:* Bleeding has been reported in patients taking Motrin and coumarin.

Pregnancy and nursing mothers: Motrin should not be taken during pregnancy or by nursing mothers.

Adverse Reactions

Incidence greater than 1%

Gastrointestinal: The most frequent type of adverse reaction occurring with Motrin is gastrointestinal (4% to 16%). This includes nausea,* epigastric pain,* heartburn,* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness,* headache, nervousness. **Dermatologic:** Rash* (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

*Incidence 3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

Dosage and Administration: Rheumatoid arthritis and osteoarthritis, including flares of chronic disease: Suggested dosage is 300, 400 or 600 mg t.i.d. or q.i.d.
Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for relief of pain.

Do not exceed 2400 mg per day.

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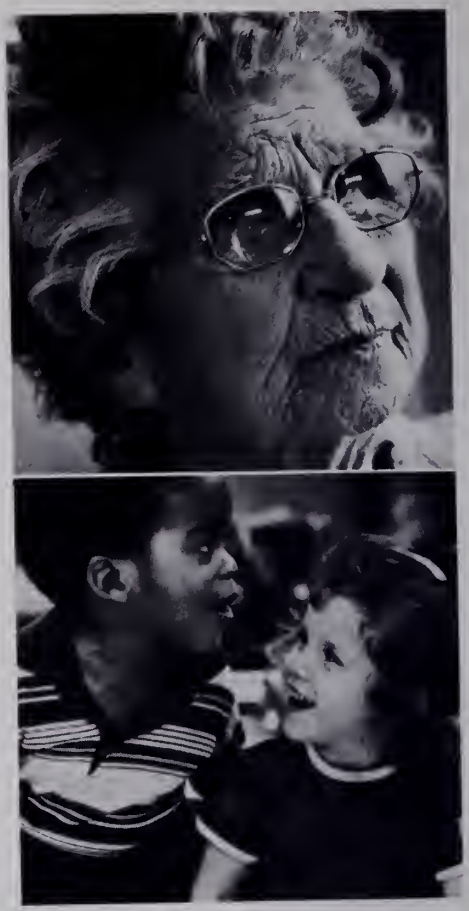
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May 1980

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But milk supplies more essential nutrients per calorie than most ther foods.

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That's why the U.S.D.A., acting on the recommendation of the ational Research Council—National Academy of Sciences, has stablished these guidelines for milk consumption:

Children up to 6 years
Two to three 8 oz. glasses per day.

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For a free copy of the Dairy Council Digest issue titled, "Com- osition and Nutrient Value of Dairy Foods," contact your local airy Council or write the National Dairy Council, 6300 North iver Road, Rosemont, Illinois 60018.

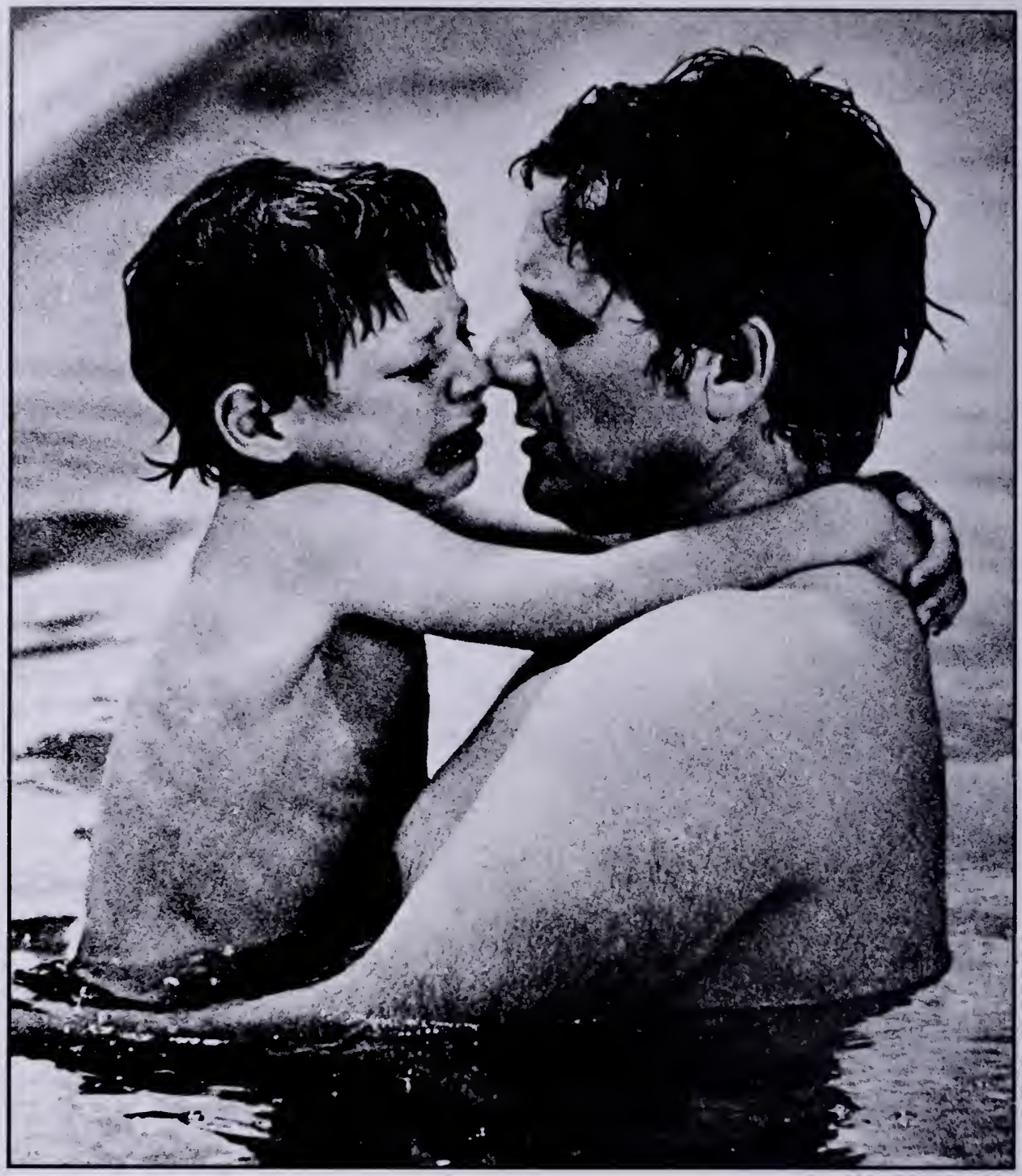
Per cent of Recommended Daily Allowance contributed by three 8 oz. glasses of fortified milk.

	6 mos.—1 yr.	1 yr.—3 yrs.	3 yrs.—6 yrs.
Calcium	100%	100%	100%
Riboflavin	100	100	100
Vitamin B_{12}	100	100	100
Protein	100	100	80
Phosphorus	100	85	85
Vitamin B_6	76	51	34
Vitamin D	75	75	75
Niacin*	71	63	47
Thiamin	56	40	31
Vitamin A	46	46	37

*maximum niacin equivalents based on: 60 mg tryptophan=1 mg niacin

ndc **National Dairy Council**

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Each tablet contains: aspirin, 325 mg; plus codeine phosphate, 30 mg, (Warning — may be habit-forming). Ⓒ III

For the millions of patients who need the potency of aspirin and codeine for their acute pain.

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Ⓒ III

DESCRIPTION: Each tablet contains aspirin (acetylsalicylic acid) 325 mg plus codeine phosphate in one of the following strengths: No. 2 — 15 mg, No. 3 — 30 mg, and No. 4 — 60 mg. (Warning — may be habit-forming.)

CONTRAINDICATIONS: Hypersensitivity to aspirin or codeine.

WARNINGS:

Drug dependence: Empirin with Codeine can produce drug dependence of the morphine type and, therefora, has th potential for being abused. Psychic dependence, physical dependence, and tolerance may develop upon repeated administration of this drug and it should be prescribed and administered with the same degrae of caution appropriate to the use of othe oral, narcotic-containing medications. Like other narcotic-containing medications, the drug is subject to tha Federal Controlled Substances Act.

Use in ambulatory patients: Empirin with Codeine may impair the mental and/or physical abilities required for th performance of potentially hazardous tasks such as driving a car or operating machinery. The patient using this drug shoul be cautioned accordingly.

Interaction with other ceotral nervous system (CNS) depressants: Patients receiving other narcotic analgesics, genera anesthetics, phenothiazines, other tranquilizers, sedative-hypnotics, or other CNS depressants (including alcohol) concomi tantly with Empirin with Codeine may exhibit an additive CNS depression. When such combined therapy is contemplated, th dose of one or both agents should be reduced.

Use in pregnancy: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development Theretore, Empirin with Codeine should not be used in pregnant women unless, in the judgment of the physician, the potentia benefits outweigh the possible hazards.

PRECAUTIONS:

Haad injury and increased intracranial pressure: The respiratory depressant effects of narcotics and their capacity t elevate cerebraspinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracraniat lesions o a pre-existing increase in intracranial pressure. Furthermore, narcotics produce advarse reactions which may obscure th clinical course of patients with head injuries.

Acute abdominal conditions: The administration of Empirin with Codeine or other narcotics may obscure tha diagnosis c clinical course in patients with acute abdominal conditions.

Allergic: Precautions should be taken in administering salicylates to persons with known allergies: patients with nas polyps are more likely to be hypersensitive to aspirin.

Special risk patients: Empirin with Codeine should be given with caution to certain patients such as the elderly o debilitated, and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, prostati hypertrophy or urathral stricture, peptic ulcer, or coagulation disorders.

ADVERSE REACTIONS: The most frequently observed adverse reactions to codeine include light-headedness, dizziness sedation, nausea and vomiting. These effects seem to be more prominent in ambulatory than in nonambulatory patients an some of these adverse reactions may be alleviated if the patient lies down Other adverse reactions include euphoria dysphoria, constipation, and pruritus.

The most frequently observed reactions to aspirin include headache, vertigo, ringing in the ears, mental confusion, drowsi ness, sweating, thirst, nausea, and vomiting. Occasional patients experience gastric irritation and bleeding with aspirin Some patients are unable to take salicylates without developing nausea and vomiting. Hypersensitivity may be manifested a skin rash or even an anaphylactic reaction. With these exceptions, most of the sida effects occur after repeated administ tion of large doses.

DOSAGE AND ADMINISTRATION: Dosage should be adjusted according to the seventy of the pain and the response patient It may occasionally be necessary to exceed the usual dosage recommended below in cases of more severe pain those patients who have become tolerant to the analgesic affect of narcotics. Empirin with Codeine is given orally. The adult dose for Empirin with Codeine No. 2 and No. 3 is one or two tablets every four hours as required. The usual for Empirin with Codeine No. 4 is ona tablet every four hours as required.

DRUG INTERACTIONS: The CNS depressant effects of Empirin with Codeine may be additive with that of other CNS depressants. See WARNINGS.

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SPECIAL ARTICLES

The Relationship Between Insurance Companies and the Practicing Physician

Richard B. MacKenzie, M.D.

The relationship between insurance companies and the practicing physician could be described as a prototype of the love-hate relationship. Since the early days of medical schools we have learned the art of dodging our friends (and ex-friends) who, having become aspiring young insurance executives, found the fledging doctor an easy prey for their salesmanship. On the other side of the coin, however, the insurance companies are our only customers who promptly, and sometimes almost cheerfully, pay our bills.

When asked to discuss the feelings of a practicing physician about insurance medicine, it seems appropriate to provide some insight into how physicians react — both personally and professionally, to requests for medical information from insurors. This entire business is somewhat of a double-edged sword. As a physician, concerned about the welfare of our patient, we certainly do not wish to jeopardize his ability to obtain insurance. At the same time, we must realize when we cash your check, we have contracted to provide you with sufficient information to assess risk factors. As a result, a compromise situation usually results.

I will cite an example to illustrate this dilemma. A while back I received a request for information on a patient who had been coming to me with his family for a number of years. The only time I ever saw this man was to do a yearly physical for his fitness club. He was perhaps the healthiest patient in my practice. On his most recent visit, he requested a referral for psychological counselling for some marital problems. This was done, the consultation made and the situation resolved. When asked for a diagnosis on his form I wrote "anxiety" and outlined the reasons. His request for insurance was refused and he stormed into my office demanding an explanation. I wrote to the insurance company for clarification and was informed that risk could not be accurately assessed for such a diagnosis, forcing them to decline the policy.

The question naturally arises out of all this: "Are we selective in our replies to insurance requests?" And the answer is a qualified yes. In the example I cited, were I to do it again, I would have omitted the diagnosis of anxiety. In my opinion it has no bearing on his insurability. You could certainly argue that it is not my job to underwrite insurance policies, but merely provide the facts so that insurors can do so. Unfortunately, this seems to be the only way of being fair to both my patient and client.

To what extent do we and, indeed, can we carry this selectivity? If a patient is hypertensive, for example, would we crib his readings? No, most certainly not. However if an otherwise healthy individual has one slightly elevated reading under a stressful situation which subsequently normalizes, we might omit this finding. If I know a patient is an alcoholic, I would feel obliged to include this in his assessment as it certainly affects his risk potential. If the patient is a tense, emotionally labile individual with no evidence of psychological instability, I would play this down for his insurance evaluation. All in all — important things are not excluded, but neither will I submit a verbatim transcript of my notes without qualification.

Another question I was asked to consider was whether we consider insurance forms an infringement on our time. I think most physicians would say no. Insurance companies, as a rule, pay physicians well enough to supply them with information to justify the time spent. If my report warrants a higher fee because of degree of difficulty, I do not hesitate to bill more for this and, as yet, I have not been challenged for doing so.

Insurance companies employ sound psychological

Dr. MacKenzie is a member of the active staff, New York General Hospital, and Lecturer, Department of Family Medicine, University of Toronto. This address was originally presented in January 1980 at the Canadian Home Office Life Underwriters Association Seminar.

tactics in dealing with physicians: Ontario Hospital Insurance Plan (government subsidized health insurance) and/or patients pay us, sometimes, when they feel like it, and often not for months after the service. Insurance companies pay always, usually immediately, and often better.

What about insurance physical examinations? I suppose this is very much a personal observation, but I quite enjoy doing these. As a rule the patients are healthy. And those who are not usually effect miraculous cures prior to coming for their physicals. The examinations are not particularly onerous or time-consuming and often provide a break in an otherwise hectic day.

However, doing insurance physicals evokes somewhat of a different response in physicians from that of requests for information. When I walk into my examination room with a patient referred for an insurance assessment, I conduct myself as an employee of that insurance company hired to use my expertise to look for and uncover any risk factors affecting his insurability. It is certainly easier to be objective when assessing someone who is not a patient.

What suggestions would I make to change the present format for insurance physical assessments, forms, etc.? This question gave me a little license to philosophize — an opportunity I always welcome. Firstly, major risk factors are largely ignored on insurance forms. 1. None of these seems to make any mention of probably the number one health hazard in our society, smoking. It has always annoyed me to be rated as an insurance risk equivalent to a three pack a day cigarette smoker. 2. Obesity is another major risk factor which is given little attention on insurance forms. 3. No consideration is given to the individual who is physically fit. 4. There is no provision in the insurance form to detail any type of physical activity or, 5. for the physician's assessment of physical fitness. I have examined 300 pound porpoises who smoke 40 cigarettes a day and whose only exercise is shaking their martinis, and have seen them rated at half the premium of a lean, non-smoking, abstemious athlete with a functional heart murmur. We know these inequities exist and they need be changed.

Surely the insurance examination is one of the most fertile situations for the practice of preventive medicine. Nobody should be more interested in the health and welfare of premium-paying customers than insurors. Similarly, if physicians are doing their job properly, they should be applying the most strenuous efforts towards helping patients to live longer, healthier lives. Why then, could we not act more in concert to achieve this same objective?

At present you rate a patient's policy for health problems such as hypertension, heart disease, diabetes or proteinuria because of the obvious association of these factors with earlier demise. Unfortunately, these penalties must be applied for conditions beyond the patient's ability to control.

Why then, I propose, could we not develop certain *positive* incentives to encourage the individual to modify the so-called "self-inflicted" risk factors that do not presently influence his insurability? 1. Why not offer a premium reduction for insurance applicants who are non-smokers? 2. Similarly a premium penalty could be applied to smokers which could subsequently be withdrawn when the person demonstrates that he has kicked the habit? 3. A similar policy could be adopted for the obese individual who "corrects" his risk factor by losing weight. 4. Or why not offer similar concessions to an alcoholic who seeks and respnds to treatment? 5. Why not give a break from the outset to non-drinkers as for the abstainers car insurance? 6. And how about the poor unfortunate guy with mild essential hypertension who follows his medical treatment religiously and keeps his pressures under good control? Surely his risk is substantially lower than the untreated hypertensive and he should merit a corresponding premium reduction.

I would like to reiterate my feeling that the insurance company and the practicing physician are in a unique position to act cooperatively to influence positively the health of our respective clients and patients. The concept of an adversary relationship with patient and doctor aligned against the mercenary insurance company will certainly defeat this purpose.

NIH Consensus Development Conference

Thrombolytic Therapy in Thrombosis

A National Institutes of Health Consensus Development Conference, held at NIH April 10-12, 1980, addressed the issue of thrombolytic therapy* for the management of acute deep-vein thrombosis and pulmonary embolism.

At NIH, consensus development conferences bring together biomedical research scientists, practicing physicians, consumers, and others as appropriate in an effort to reach general agreement on the safety and effectiveness of a medical technology. That technology may be a drug, device, or medical or surgical procedure.

A consensus development panel, after listening to expert presentations at the NIH conference on Thrombolytic Therapy in Thrombosis, issued the following consensus statement:

For over three decades, the primary method of therapy used by almost all physicians for the management of acute deep-vein thrombosis and pulmonary embolism has been anticoagulation. This form of therapy has become so ingrained in medical practice that physicians, while still concerned over the bleeding risk associated with the use of anticoagulants, nevertheless seem secure in the belief that they are providing optimal, if not ideal, therapy for these disorders. With the advent of thrombolytic therapy, this is no longer true for a large number of cases. Anticoagulation for the management of acute deep-vein thrombosis and pulmonary embolism, while usually effective in preventing or slowing further thrombus formation in veins and significantly diminishing the likelihood of subsequent or recurrent embolization, does not:

- eliminate the source of subsequent embolization in the deep veins during the acute attack;
- alleviate the hemodynamic disturbances associated with the thrombosis or embolism;
- prevent subsequent valvular damage to the deep veins and the development of persistent venous hypertension and associated symptomatology in the lower extremities which may predispose to recurrent deep-vein thrombosis and pulmonary embolism; and
- prevent permanent impairment to the pulmonary vascular bed and, in patients with more extensive involvement, persistence of pulmonary hypertension.

*The thrombolytic agents considered at this consensus development conference were urokinase and streptokinase.

The reason that patients with acute deep-vein thrombosis and pulmonary embolism treated with anticoagulation alone are subject to these complications is that such therapy has no acute effect on previously formed thrombi or emboli. Its role is primarily that of secondary intervention, i.e., prophylaxis against further thrombus growth, recurrence and embolization. The natural history of underlying thrombi and emboli treated with anticoagulation alone is mainly one of organization and recanalization.

From these considerations it is apparent that ideal therapy for acute deep-vein thrombosis and pulmonary embolism requires either the surgical removal or lysis of the thrombus or embolus so as to restore to normal the hemodynamics and integrity of the vasculature, and the subsequent prevention of recurrence of thrombosis. On the basis of present experience, a surgical approach is usually unsuccessful except under very limited conditions.

However, the lysis of thrombi and emboli can be successfully accomplished in a large number of patients through the proper use of thrombolytic agents. When used in conjunction with anticoagulants, thrombolytic therapy can achieve the objectives of ideal management as follows:

- lyse thrombi and emboli and restore the circulation to normal,
- normalize the hemodynamic disturbances and reduce morbidity,
- prevent venous valvular damage and subsequent venous hypertension in the lower extremities, and
- prevent permanent damage to the pulmonary vascular bed and reduce the likelihood of persisting pulmonary hypertension.

While there are compelling reasons to use this new form of therapy in the management of acute deep-vein thrombosis and pulmonary embolism, it must be recognized that there are risks associated with the use of thrombolytic therapy. Therefore, the administration of thrombolytic agents should be encouraged only in those situations where the benefits to be achieved outweigh the hazards involved. At present this would be for those patients who are suffering from proximal deep-vein thrombosis, i.e., thrombosis involving the popliteal vein or the deep veins of the thigh and pelvis and for those with pulmonary emboli with significant hemodynamic disturbances or where there has been obstruction of

blood flow to a lobe or multiple segments providing:

- the diagnosis is established;
- the severity of the clinical problem exceeds the risk of bleeding associated with a major contraindication.
- proper care is taken in the handling of the patient and in the avoidance of any but absolutely essential invasive procedures; and
- there is a clear understanding of the details of therapy including monitoring, management of bleeding complications, and the control of subsequent anticoagulation.

When properly used, in tandem with anticoagulation, thrombolytic therapy as currently practiced represents a significant advance in the management of proximal acute deep-vein thrombosis and the more severe forms of pulmonary embolism. With further developments aimed at improvings its efficacy and reducing the bleeding risk, this form of therapy could become the initial treatment for all forms of acute deep-vein thrombosis and pulmonary embolism.

This consensus statement was arrived at following discussion of a series of questions.

I. Are there proven benefits for the use of thrombolytic therapy in currently approved indications, i.e., the more severe forms of acute deep-vein thrombosis and pulmonary embolism?

There are proven benefits as follows:

- Thrombolytic therapy lyses thrombi in the deep venous system and emboli in the pulmonary circulation, and the thrombi and emboli disappear more rapidly than with heparin therapy. These observations are based upon a number of controlled clinical trials in which treatment efficacy was assessed by objective means such as serial pulmonary angiography, perfusion lung scanning and contrast venography.
- Thrombolytic therapy results in a greater improvement or normalization of the abnormal hemodynamic responses to pulmonary embolization than is observed with heparin theapy. These observations are based upon serial studies of selected hemodynamic measurements from the right heart and pulmonary circulation. It has also been shown that lessening of pulmonary hypertension may be observed as early as one and a half hours following initiation of thrombolytic therapy, reaching a maximum in approximately six hours.
- Thrombolytic therapy helps to prevent venous valvular damage and subsequent venous hypertension in the extremities by rapid and more complete lysis of thrombi. It has been demonstrated that patients treated with thrombolytic therapy have a much higher frequency of maintenance of intact and functioning venous valves than do patients treated with heparin alone.
- Thrombolytic therapy may prevent permanent damage to the pulmonary vascular bed by lysing emboli and restoring the pulmonary circulation to normal. In contrast, it has been observed that residual emboli usually persist in patients treated with heparin alone. The presence of such residual emboli, especially significant in those suffering recurrent pulmnary embolism, may result in persistent pulmonary hypertension.

II. What are the risks associated with the use of thrombolytic agents?

Review of the literature indicates that of the undesirable effects associated with current thrombolytic therapy, bleeding poses the major potential risk.

The bleeding associated with thrombolytic therapy is more frequent than with conventional anticoagulants, but this is primarily related to bleeding from sites of invasive procedures. The type of bleeding observed in association with thrombolytic agents can be placed into two broad categories:

- Superficial or surface bleeding, observed mainly at invaded or disturbed sites (e.g.: venous cutdowns, arterial punctures, sites of recent surgical intervention, etc.). This type of bleeding is inherent in the nature of thrombolytic therapy since the use of thrombolytic agents is predicated on their ability to lyse fibrin. One can minimize bleeding at these sites by appropriate patient management and avoidance of procedures that disturb the integrity of the vascular system.
- Internal bleeding observed in the gastrointestinal tract, genitourinary tract, vagina, intramuscular, retroperitoneal, intracerebral, etc. Although this type of bleeding occasionally happens during thrombolytic therapy with a recognizable incidence, it is not statistically different from the incidence of bleeding seen with the conventional anticoagulants. However, there is an approximate 1 percent incidence of cerebral hemorrhage associated with thrombolytic therapy compared with a 0.5 percent incidence observed with heparin.

With the utilization of good clinical judgment many of these bleeding problems can be avoided by appropriate case selection and management.

Additional undesirable effects that have been observed in association with thrombolytic therapy

include fever and allergic reactions. These occur at a low frequency, are mild, and seldom result in any physiologic injury or the need to discontinue therapy. Anaphylactoid reactions observed with older preparations no longer in use are very rarely observed with the presently employed agents. When such reactions have been observed they uniformly respond to conventional therapy.

III. What are the guidelines for patient selection?

The presence of an appropriate clinical indication including a documented diagnosis and evidence that the thrombus is of recent origin ($\leq$7 days).

Careful evalution of contraindications which include the following:

A. **Absolute**

— Active internal bleeding
— Recent (within two months) cerebrovascular accident or other active intracranial process. There is evidence that currently used thrombolytic regimens carry the hazard of inducing cerebral hemorrhage in those with a recent history of stroke. (However, studies are currently under way using lower agent dosage for the treatment of stroke).

B. **Relative**

Major
— Recent (< 10 days) major surgery, obstetrical delivery, organ biopsy, previous puncture of non-compressible vessels
— Recent serious GI bleeding
— Recent serious trauma
— Severe arterial hypertension ($\geq$200 systolic or $\geq$110 diastolic)

Minor
— Recent minor trauma including cardio-pulmonary resuscitation
— High likelihood of a left heart thrombus, e.g., mitral disease with atrial fibrillation
— Bacterial endocarditis
— Hemostatic defects including those associated with severe hepatic or renal disease
— Pregnancy
— Age >75 years
— Diabetic hemorrhagic retinopathy

IV. Assuming there are proven benefits and a favorable risk/benefit ratio, why are these drugs not being used more frequently?

The panel agreed that while some rationales for deciding against the use of thrombolytic agents were reasonable, such as an inadequate clinical indication or the risk of serious hemorrhage, others were unreasonable. These unreasonable rationales are partly the result of reports of the large multicentered Urokinase and Streptokinase Pulmonary Embolism Trials with their complex biochemical and physiologic studies that required many invasive procedures, and also of the early experience using thrombolytic agents that were less pure than current products and which caused more frequent pyrogenic and allergenic side effects. The unreasonable rationales incude the following:

— Fear of bleeding. The Urokinase and Streptokinase Pulmonary Embolism Trials showed a high incidence of bleeding both with thrombolytic agents and with heparin. However, the incidence of significant bleeding was only 9 percent for urokinase/streptokinase and 4 percent for heparin. The incidence of major bleeding complications with lytic agents during recent clinical experience, i.e., since the drugs have been available for general physician use, has been about 5 percent. This is based on the patient treatment forms returned to pharmaceutical manufacturers during the continuing surveillance period requested by the Bureau of Biologics, Food and Drug Administration.
— Need for additional invasive procedures. The diagnostic procedures required for thrombolytic therapy are no different from those required for heparin. Objective diagnostic procedures are required for both.
— Confusion regarding dose regulation. There are many directives suggested by the package insert and the general literature that are complex and confusing. For instance, increasing the dose of streptokinase in order to decrease the proteolytic effect is scientifically accurate, but is unnecessary with a fixed dose schedule. Additionally, the streptokinase resistance test is unnecessary, given the 90 percent expectation of inducing a lytic state by the standard loading dose followed by a fixed dose schedule. Altering or eliminating such directives in the package insert would simplify treatment.
— Limited availability of laboratory assays. Although research studies utilized many highly sophisticated assays for following thrombolytic treatment, any one of a number of assays can now be utilized to reflect the circulating "lytic state," the simplest of which is the thrombin time. Whatever the choice of the physician (plasminogen, lysis time, prothrombin time, APTT, FDP's, fibrinogen, etc.) at least one of these assays will be available for use by the practitioner in any hospital laboratory.
— "Evaluate response to heparin first." Any delay in

instituting lytic therapy in order to determine whether heparin achieves an initial good response will decrease the potential for optimal response. Therefore, therapy with urokinase or streptokinase should not be deferred after the diagnosis has been established for any reason other than the presence of a serious contraindication to use.

— Decision by committee. The decision to treat need not be made by a committee; such a decision may be made by an informed clinician who is prepared to manage such a patient with a lytic agent.

V. What are the guidelines for patient management and monitoring?

— The diagnosis should be established with objective techniques. If pulmonary angiography is performed the upper extremity should be utilized.

— Before thrombolytic infusion, the following laboratory tests are indicated: A thrombin time (TT), activated partial thromboplastin time (APTT), prothrombin time (PT), hematocrit value and platelet count. If heparin has been given, it should be discontinued and the TT or APTT should be less than twice the normal control value before thrombolytic therapy is started.

— Begin the thrombolytic infusion. During therapy there should not be any invasive procedures performed with the exception of careful venepuncture with a 22 or 23 gauge needle for therapeutic monitoring. If essential, arterial blood gas studies can be performed (upper extremity) but digital compression of the puncture site for at least 30 minutes is mandatory. The patient should be at strict bed rest and pressure dressings applied to previously invaded sites. No new medication should be added to the therapeutic regimen unless absolutely essential. No medication should be added to the bottle containing the thrombolytic agent.

— Vital signs: pulse, temperature, respiratory rate and blood pressure should be performed every four hours during infusion. To avoid dislodgement of deep-vein thrombi the blood pressure should not be taken in the lower extremities.

— Therapeutic monitoring should be performed by utilizing the thrombin time or activated partial thromboplastin time (if neither is available the prothrombin time can be employed). This should be performed at 3-4 hours after institution of the thrombolytic agent (to identify and confirm activation of the fibrinolytic system). Opinions differ regarding the frequency of additional monitoring and its usefulness in predicting or controlling clinical efficacy and bleeding complications. When the TT or APTT is performed a simultaneous hematocrit value is recommended.

— Should uncontrollable bleeding commence, the thrombolytic infusion should be discontinued and, if necessary, blood loss and reversal of the bleeding tendency can be effectively managed with whole blood (fresh blood preferable), packed red blood cells and cryoprecipitate or frozen plasma.

— Following completion of the thrombolytic infusion, which will vary in duration according to the agent used and the type of the lesion being treated, e.g., deep-vein thrombosis or pulmonary embolism (see package insert for details), the patient should be placed on anticoagulants. After an interval of 3-4 hours following discontinuation of the thrombolytic agent, the TT or the APTT should be performed. When results of this test no longer exceed twice the normal control value, heparin, without a loading dose, should be instituted and controlled according to standard procedures. This should then be followed by warfarin in the conventional manner.

VI. What are the economic aspects involved in thrombolytic therapy?

The thrombolytic agents available at present, streptokinase and urokinase, are expensive drugs, especially the latter, and their use in patients with venous thrombosis or pulmonary embolism increases the cost of management of the acute thrombotic event. On the other hand, the economic burden imposed on society by the late morbidity of proximal venous thrombosis may be relieved by more widespread use of thrombolytic therapy, which under optimal circumstances restores venous patency and valvular function and prevents the subsequent development of the post-phlebitic syndrome. Patients with phlebographic demonstration of complete lysis of proximal venous thrombi by thrombolytic treatment are spared the usual sequelae of venous stasis and their associated costs, which have been estimated at a total of nearly $40,000 per patient over a ten-year period, in severe cases. The frequency of post-thrombotic sequelae in patients with thrombi in the popliteal, femoral, or illiac veins is sufficiently high to make thrombolytic therapy cost-effective in this patient group. In pulmonary embolism, analysis of cost/benefit ratio is more difficult, for no monetary value has been assigned to the late benefits of improved pulmonary capillary flow and freedom from pulmonary hypertension that appear to follow the use of thrombolytic agents. Analysis of the economic aspects of this issue awaits further data.

VII. What should be the direction for future clinical research?

During the first day of the conference, the basic biochemistry of the fibrinolytic system as it relates to thrombolytic agents was reviewed. The highlights of this session included a discussion of the following: 1) specific activators of plasminogen, including high and low molecular weight urokinase; 2) the mechanism of action of streptokinase-plasminogen activator; 3) the physiological activators of plasminogen; 4) natural inhibitors of plasmin and urokinase, including the kinetics of inhibition of plasmin by α_2 antiplasmin 5) the clinical manifestations of a patient with an abnormal plasminogen which resulted in a thrombotic tendency; 6) the use of synthetic substrates for assessment of various components of the fibrinolytic system; and 7) the detailed biochemical characterization of glu and lys plasminogen. Mechanisms of in vivo fibrinolysis were reviewed. In addition, a newly identified plasma protein (histidine rich glycoprotein), which has the capacity to block the binding of plasminogen to fibrin, was reported. Preliminary data suggested that human tissue activator of plasminogen was a more selective activator of fibrinolysis than urokinase.

— On the basis of the foregoing, the possible therapeutic role of new thrombolytic agents should be evaluated, such as SK-plasminogen complex, activators of tissue origin, B chain-SK complex and the like.

— There is also a need for further evaluation of current tests in terms of predicting thrombolytic success and bleeding. In addition, simple and practical tests reflecting or indicative of fibrin (thrombus) dissolution are highly desirable and would be a substanial contribution to further progress in this field.

Further clinical research is also required to evaluate the effects of different regimens involving dosage, durations and combinations with other agents, e.g., plasminogen and heparin. More information is needed on the efficacy and diminished risk of bleeding when SK or UK is administered regionally rather than systemically. Investigations should also be encouraged for other indications of thrombolysis, including acture myocardial infarction.

Reprinted from the NIH Consensus Development Conference Report.

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Who Is Elected in a Marriage?

Mrs. Richard B. (Connie) Moore

Political observers note that this year's presidential general election will not be between Jim and Ron but will be between Rosalyn and Nancy.

They are of course referring to the spouses of President Jimmy Carter (D) who is seeking reelection and former Governor Ronald Reagan (R) who is hoping to beat him.

This humorous reference to the power of spouses in campaigns points up a possible future dilemma in the American electoral process. In fact, it is a dilemma which many couples, of whom one is an officeholder, are facing today.

Both partners usually hold jobs in today's modern marriage. As women gain status in the work place, men and women began sharing equally the tasks of career and home. This sharing could lead to problems for the officeholder in a marriage.

A recently elected congressman is facing this dilemma today. His spouse gave up her career to campaign full time for him. She considers that in a sense she threw her whole efforts into his election, that she holds the office equally with him. This raises the question of who was really elected to the office. Was it the congressman alone or, was the husband and wife team elected, both of whom spent full time campaigning for the office.

As more families have two adults in the work force, and as equality of the sexes becomes more of an acceptable concept (having nothing to do with whether or not the Equal Rights Amendment becomes a part of the United States Constitution) the concept of a spouse helping a partner in whatever endeavor and then sharing in the responsibility and authority will become more of a dilemma.

Right now, legally the person elected is the person who serves and no legal status can be given to any other member of the family as a part of the officeholder's responsibility. There probably never should be any legal status given to more than one person in an elected or appointed office. However, more and more husband and wife teams will run together and certainly share a good deal more of the decision making processes which go hand in hand with being an elected official.

Reprinted from the *AMPAC Political Stethoscope*, July 1980. Mrs. Moore is a member of the AMPAC Board of Directors and is a former president of the FMA Auxiliary. Her husband is a practicing urologist in West Palm Beach.

The Grievance Committee

The Hillsborough County Medical Association's Grievance Committee is composed in any one year of the last three consecutive ex-presidents plus two presidential appointees. It meets at least six times a year and each session represents a minimum of 90 hours of physician time 200 hours of secretarial time, and 9,600 pages of paperwork.

Who complains to the Grievance Committee? Basically those people whose problems do not properly fall under the jurisdiction of the Insurance Review Committee or the Board of Censors. The Grievance Committee is not a disciplinary committee but rather a fact-finding, arbitrating group which seeks to offer conciliatory advice to both the physician and the person initiating the complaint. If, however, a physician's name comes before the committee three or more times, he is reported to the Board of Censors.

Patients who contact the Grievance Committee are required to write out and sign a complaint. The physician named is contacted; his records (as well as those of the hospital, if pertinent) are reviewed by all members of the committee. One member, however, is assigned the case

in order to follow up with any additional desired or necessary information and to compose the nucleus of a written reply to the patient (a copy of which is sent to the physician).

It appears that persons who approach the Grievance Committee rarely initiate a malpractice action. This is usually, of course, because the case is without true malpractice merit but rather involves hurt or injuries which would not be addressed or redressed by a court of law. Often the patient believes that the attitude of the physician needs to be reported and there seems to be a hope that this may be corrected for the good of all.

It goes without saying that there are frequent letters without real merit from persons who show varying degrees of mental derangement, but these are in the minority. Medicine seems to have been the last profession or perhaps the last business to learn that "the customer is always right."

The most frequent complaints received from month to month, year in and year out, are the same. They deal with these issues:

(1) **Lack of communication:** Sometimes this is simply "I can't get through to him on the telephone" or "He never returns my calls." besides these multiple examples of lack of communication, there is poor communication such as "He never told me that I would have a scar if he operated on me." The committee urges all members to (1) take the time to return all calls and to do so promptly, (2) not to allow their assistants to be over-protective of their time, and (3) to be certain that someone of responsible age and mental competence in a position of family relationship and responsibility understands the disease, its effects, course, and alternative forms of treatment. In the case of either a minor or an elderly person, it seems wise if not necessary to have someone else along when explanations are offered, permits signed, etc. This is also helpful with husband and wife in many cases. More than one or two "witnesses," however, are usually counterproductive, and the physician should always deal with the same original ones.

(2) **Money:** Many letters to the committee directly follow a collection letter. Be careful how your office handles this matter, giving the patient an opportunity to explain why payment has not been made and urging some plan of payment rather than jumping directly to the threat of a collection agency. If you use an agency, be careful to use a reputable one whose goal it is to help the family manage its debts and not merely to get "first" money.

(3) Many complaints center about the refusal of a physician to provide a patient with an itemized statement of charges — or even an explanation. We are legally obligated to provide an itemized statement. The best way to avoid misunderstanding is to be sure that the patient understands your payment policies (and whenever possible your charges) beforehand. Always be certain that some mature and well-informed employee explains all charges to the inquiring patient, undefensively. Many people, stunned by any initial statement will willingly pay a fair charge, once they understand its derivation.

(4) A few charges unfortunately deal with unprofessional conduct on the part of physicians, ranging from improper advances to resented informality.

(5) There are few complaints alleging unnecessary surgery but there are many questions about why Dr. Consultant came in for a visit. Sometimes it is simply: "Dr. Consultant sent me a bill and he never saw me and I never heard of him." This latter case may be because the patient was in the ICU for several days, and although he did not see Dr. Consultant, Dr. Consultant saw him several times a day but did not keep in touch with the family or inform the patient himself after the patient had improved. If you consult, be sure to introduce yourself and state that Dr. Attending asked you to come by and why. Better still, no consultant should ever be called to see a conscious, competent, or familied patient without the patient's being first informed by Dr. Attending. (For example they may wish to use Dr. X instead of Dr. Y since they have been seeing him professionally or socially for ten or twenty years).

This is one committee that we hope you will never become better acquainted with (beyond this page), but we do stand ready to arbitrate and the typical physician is helpful to us as we attempt to help him and his patient to an understanding which may have been temporarily set aside.

Our committee has relatively little work for such a large Association with close to a thousand members because nearly all of our members care very much about what their colleagues think of them and desire to practice good medicine and to help their fellow man.

Joel Mattison, M.D.

Reprinted from the Hillsborough County Medical Association Bulletin, March 1980.

ANNOUNCEMENT OF MEETING

FLORIDA SYMPOSIUM ON

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Dept. of Nutrition and Food Science
Faculty of Medicine
University of Toronto
Toronto, Ontario, Canada

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Phillips Professor of Medicine
Kansas University Medical Center
Kansas City, Kansas

GARY W. EVANS, PH.D.
Research Chemist
Human Nutrition Laboratory
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Peer Medical Utilization Review: Conformity or Avoidance?

Charles B. Mutter, M.D.

What Is Peer Review?

Peer review is the review of a physician's pattern of practice by his fellow physicians. It is as old as medicine itself and has constructive impact. Peer review for Medicare is a privilege granted by our government to permit other physicians to review a doctor's Medicare practice when a question arises regarding treatment rendered to Medicare recipients. When a doctor has a pattern of practice which differs significantly from that of his fellows in a similar field, this difference is detected by a routine computer review of physician "profiles", and an attempt is made by the Medicare carrier to understand these differences (this subject will be examined further in a future article). Occasionally these differences are not resolved, and Peer Medical Utilization Review is requested.

The doctor is greatly inconvenienced. Time, his most important commodity, is required to obtain charts; review his records; appear before a county committee and sometimes a state committee; and to explain further his practice pattern, to justify orders, certain lab tests, frequency and necessity of office visits, injections and special procedures. He may feel intimidated, anxious, harrassed and that it is a waste of time which detracts from his patients and his income.

As previously stated, peer review is a privilege, and the doctor has a right to waive the process. If allowed this option, why should he subject himself to this time consuming, anxiety provoking situation?

The advantages of review by peers are several. The doctor can use his own terminology, permitting greater ease of communication, and eliminating the need to define terms. He can obtain feedback about the current patterns of practice and learn additional concepts which may assist him in his practice. He can discover how he compares with his colleagues, which can be edifying. Since learning can be mutually beneficial, the doctor often aids the committee, and new issues can be discussed.

Perhaps most important in the peer review process is the opportunity it allows a doctor who appears to have overutilized certain benefits to show that his pattern of practice is necessary because of the type of patient he treats, and the complications he encounters. In the majority of the doctors reviewed, the committee resolves the conflicting patterns of practice after hearing a physician's reasons.

When the committee determines that a doctor has unjustifiably overutilized benefits it may offer guidelines to help him improve his pattern of practice and avoid future problems. This result of peer review alone is highly cost efficient for the doctor as well as the consumer. The educational value of such guidelines also allows the doctor to provide higher quality care.

Peer review affords the doctor an opportunity to explain his pattern of practice, to obtain guidelines when necessary, and help establish guidelines which are often constructive in future committee reviews. If the doctor being reviewed does not agree with the committee's findings, he has the option of appeal, and a hearing before a Medicare Hearing Officer (usually a lay person).

Peer review is not a waiver of due process. It is, rather, an additional process which offers a more objective review. Although it is not legally binding, the findings of the committee are usually respected and followed by the carrier.

The responsibility of the PMUR Committee is to

This is the second in a series prepared under the auspices of the FMA Committee on Peer Medical Utilization Review.

Dr. Mutter is a psychiatrist in private practice in Miami, and is Chairman of the PMUR Committee.

conduct a highly objective review of a doctor's pattern of practice. Three guidelines help assure this aim: medical necessity, quality of care and reasonable cost.

In the experience of the Florida PMUR Committee, most doctors have derived benefit from the process despite anxiety and time consumed. On infrequent occasions very inept doctors have been discovered, and appropriate steps taken, which has resulted in benefits to all physicians and consumers.

Future articles in this series will deal with in-house review, concurrent care, how to prepare for peer reveiw, the carrier's action upon receipt of a finding, and the Medicare Fair Hearing itself.

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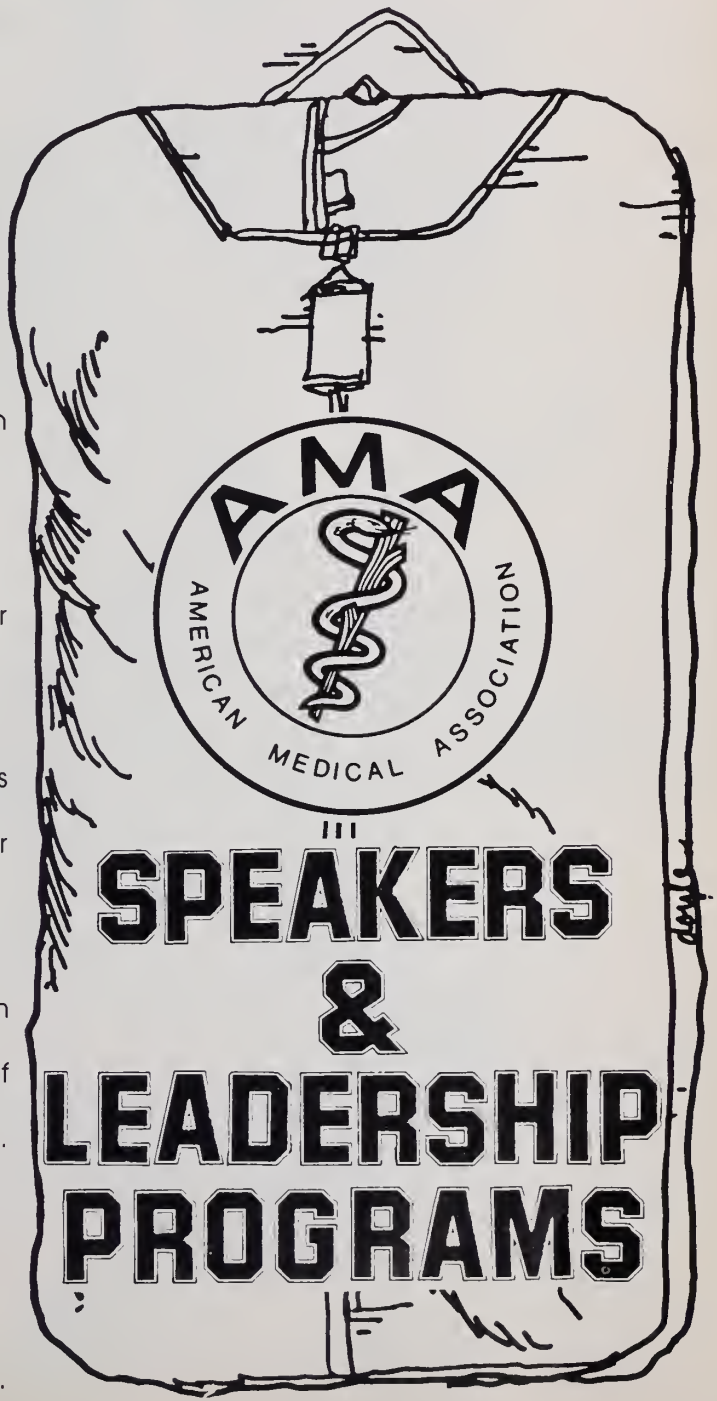
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CONTRAINDICATIONS: Central nervous system depression from drugs (barbiturates, alcohol, narcotics, analgesics, antihistamines); evidence of bone marrow depression; known hypersensitivity to phenothiazines or amitriptyline. Should not be given concomitantly with a monoamine oxidase inhibitor since hyperpyretic crises, severe convulsions, and deaths have occurred from such combinations. When used to replace a monoamine oxidase inhibitor, allow a minimum of 14 days to elapse before initiating therapy with TRIAVIL. Therapy should then be initiated cautiously with gradual increase in dosage until optimum response is achieved. Not recommended for use during acute recovery phase following myocardial infarction.

WARNINGS: TRIAVIL should not be given concomitantly with guanethidine or similarly acting compounds since TRIAVIL may block the antihypertensive action of such compounds. Use cautiously in patients with history of urinary retention, angle-closure glaucoma, increased intraocular pressure, or convulsive disorders. Dosage of anticonvulsive agents may have to be increased. In patients with angle-closure glaucoma, even average doses may precipitate an attack. Patients with cardiovascular disorders should be watched closely. Tricyclic antidepressants, including amitriptyline HCl, have been reported to produce arrhythmias, sinus tachycardia, and prolongation of conduction time, particularly in high doses. Myocardial infarction and stroke have been reported with tricyclic antidepressant drugs. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. May impair mental and/or physical abilities required for performance of hazardous tasks, such as operating machinery or driving a motor vehicle. TRIAVIL may enhance the response to alcohol and the effects of barbiturates and other CNS depressants. In patients who use alcohol excessively, potentiation may increase the danger inherent in any suicide attempt or overdosage. Not recommended in children or during pregnancy.

PRECAUTIONS: Suicide is a possibility in depressed patients and may remain until significant remission occurs. Such patients should not have access to large quantities of this drug.

Perphenazine: Should not be used indiscriminately. Use with caution in patients who have previously exhibited severe adverse reactions to other phenothiazines. Likelihood of some untoward actions is greater with high doses. Closely supervise with any dosage. The antiemetic effect of perphenazine may obscure signs of toxicity due to overdosage of other drugs or make more difficult the diagnosis of disorders such as brain tumor or intestinal obstruction. A significant, not otherwise explained, rise in body temperature may suggest individual intolerance to perphenazine, in which case discontinue.

If hypotension develops, epinephrine should not be employed, as its action is blocked and partially reversed by perphenazine. Phenothiazines may potentiate the action of central nervous system depressants (opiates, analgesics, antihistamines, barbiturates, alcohol) and atropine. In concurrent therapy with any of these, TRIAVIL should be given in reduced dosage. May also potentiate the action of heat and phosphorous insecticides. Neuroleptic drugs elevate prolactin levels; the elevation persists during chronic administration. Tissue culture experiments indicate that approximately one-third of human breast cancers are prolactin dependent *in vitro*, a factor of potential importance if the prescription of these drugs is contemplated in a patient with a previously detected breast cancer. Although disturbances such as galactorrhea, amenorrhea, gynecomastia, and impotence have been reported, the clinical significance of elevated serum prolactin levels is unknown for most patients. An increase in mammary neoplasms has been found in rodents after chronic administration of neuroleptic drugs. Neither clinical studies nor epidemiologic studies conducted to date, however, have shown an association between chronic administration of these drugs and mammary tumorigenesis; the available evidence is considered too limited to be conclusive at this time.

Amitriptyline: In manic-depressive psychosis, depressed patients may experience a shift toward the manic phase if they are treated with an antidepressant. Patients with paranoid symptomatology may have an exaggeration of such symptoms. The tranquilizing effect of TRIAVIL seems to reduce the likelihood of this effect. When amitriptyline HCl is given with anticholinergic agents or sympathomimetic drugs, including epinephrine combined with local anesthetics, close supervision and careful adjustment of dosages are required. Paralytic ileus may occur in patients taking tricyclic antidepressants in combination with anticholinergic-type drugs.

Caution is advised if patients receive large doses of ethchlorvynol concurrently. Transient delirium has been reported in patients who were treated with 1 g of ethchlorvynol and 75-150 mg of amitriptyline HCl.

Concurrent administration of amitriptyline HCl and electroshock therapy may increase the hazards associated with such therapy. Such treatment should be limited to patients for whom it is essential. Discontinue several days before elective surgery if possible. Elevation and lowering of blood sugar levels have both been reported. Use with caution in patients with impaired liver function.

ADVERSE REACTIONS: Similar to those reported with either constituent alone.

Perphenazine: Extrapyramidal symptoms (opisthotonus, oculogyric crisis, hyperreflexia, dystonia, akathisia, acute dyskinesia, ataxia, parkinsonism) have been reported and can usually be controlled by the concomitant use of effective antiparkinsonian drugs and/or by reduction in dosage, but sometimes persist after discontinuation of the phenothiazine.

Tardive dyskinesia may appear in some patients on long-term therapy or may occur after drug therapy with phenothiazines and related agents has been discontinued. The risk appears to be greater in elderly patients on high-dose therapy, especially females. Symptoms are persistent and in some patients appear to be irreversible. The syndrome is characterized by rhythmical involuntary movements of the tongue, face, mouth, or jaw. Involuntary movements of the extremities sometimes occur. There is no known treatment for tardive dyskinesia; antiparkinsonism agents usually do not alleviate the symptoms. It is advised that all antipsychotic agents be discontinued if the above symptoms appear. If treatment is reinstituted, or dosage of the particular drug increased, or another drug substituted, the syndrome may be masked. Fine vermicular movements of the tongue may be an early sign of the syndrome. The full-blown syndrome may not develop if medication is stopped when lingual vermiculation appears.

Other side effects are skin disorders (photosensitivity, itching, erythema, urticaria, eczema, up to exfoliative dermatitis); other allergic reactions (asthma, laryngeal edema, angioneurotic edema, anaphylactoid reactions); peripheral edema; reversed epinephrine effect; hyperglycemia; endocrine disturbances (lactation, galactorrhea, gynecomastia, disturbances of menstrual cycle); altered cerebrospinal fluid proteins; paradoxical excitement; hypertension, hypotension, tachycardia, and ECG abnormalities (quinidine-like effect); reactivation of psychotic processes; catatonic-like states; autonomic reactions, such as dry mouth or salivation, headache, anorexia, nausea, vomiting, constipation, obstipation, urinary frequency or incontinence, blurred vision, nasal congestion, and a change in pulse rate; other adverse reactions reported with various phenothiazine compounds, but not with perphenazine, include grand mal convulsions, cerebral edema, polyphagia, pigmentary retinopathy, photophobia, skin pigmentation, and failure of ejaculation.

The phenothiazine compounds have produced blood dyscrasias (pancytopenia, thrombocytopenic purpura, leukopenia, agranulocytosis, eosinophilia) and liver damage (jaundice, biliary stasis).

Pigmentation of the cornea and lens has been reported to occur after long-term administration of some phenothiazines. Although it has not been reported in patients receiving TRIAVIL, the possibility that it might occur should be considered.

Hypnotic effects, lassitude, muscle weakness, and mild insomnia have also been reported.

Amitriptyline: Note: Listing includes a few reactions not reported for this drug, but which have occurred with other pharmacologically similar tricyclic antidepressant drugs and must be considered when amitriptyline is administered. *Cardiovascular:* Hypotension; hypertension; tachycardia; palpitation; myocardial infarction; arrhythmias; heart block; stroke. *CNS and Neuromuscular:* Confusional states; disturbed concentration; disorientation; delusions; hallucinations; excitement; anxiety; restlessness; insomnia; nightmares; numbness, tingling, and paresthesias of the extremities; peripheral neuropathy; incoordination; ataxia; tremors; seizures; alteration in EEG patterns; extrapyramidal symptoms; tinnitus; syndrome of inappropriate ADH (antidiuretic hormone) secretion. *Anticholinergic:* Dry mouth; blurred vision; disturbance of accommodation; increased intraocular pressure; constipation; paralytic ileus; urinary retention; dilatation of urinary tract. *Allergic:* Skin rash; urticaria; photosensitization; edema of face and tongue. *Hematologic:* Bone marrow depression including agranulocytosis; leukopenia; eosinophilia; purpura; thrombocytopenia. *Gastrointestinal:* Nausea; epigastric distress; vomiting; anorexia; stomatitis; peculiar taste; diarrhea; parotid swelling; black tongue. Rarely hepatitis (including altered liver function and jaundice). *Endocrine:* Testicular swelling and gynecomastia in the male; breast enlargement and galactorrhea in the female; increased or decreased libido; elevated or lowered blood sugar levels. *Other:* Dizziness, weakness; fatigue; headache; weight gain or loss; increased perspiration; urinary frequency; mydriasis; drowsiness; alopecia. *Withdrawal Symptoms:* Abrupt cessation after prolonged administration may produce nausea, headache, and malaise. These are not indicative of addiction.

OVERDOSAGE: All patients suspected of having taken an overdosage should be admitted to a hospital as soon as possible. Treatment is symptomatic and supportive. However, the intravenous administration of 1–3 mg of physostigmine salicylate is reported to reverse the symptoms of tricyclic antidepressant poisoning. Because physostigmine is rapidly metabolized, the dosage of physostigmine should be repeated as required particularly if life-threatening signs such as arrhythmias, convulsions, and deep coma recur or persist after the initial dosage of physostigmine. On this basis, in severe overdosage with perphenazine-amitriptyline combinations, symptomatic treatment of central anticholinergic effects with physostigmine salicylate should be considered.

1180 (DC66132)

For more detailed information, consult your MSD Representative or see full Prescribing Information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486.

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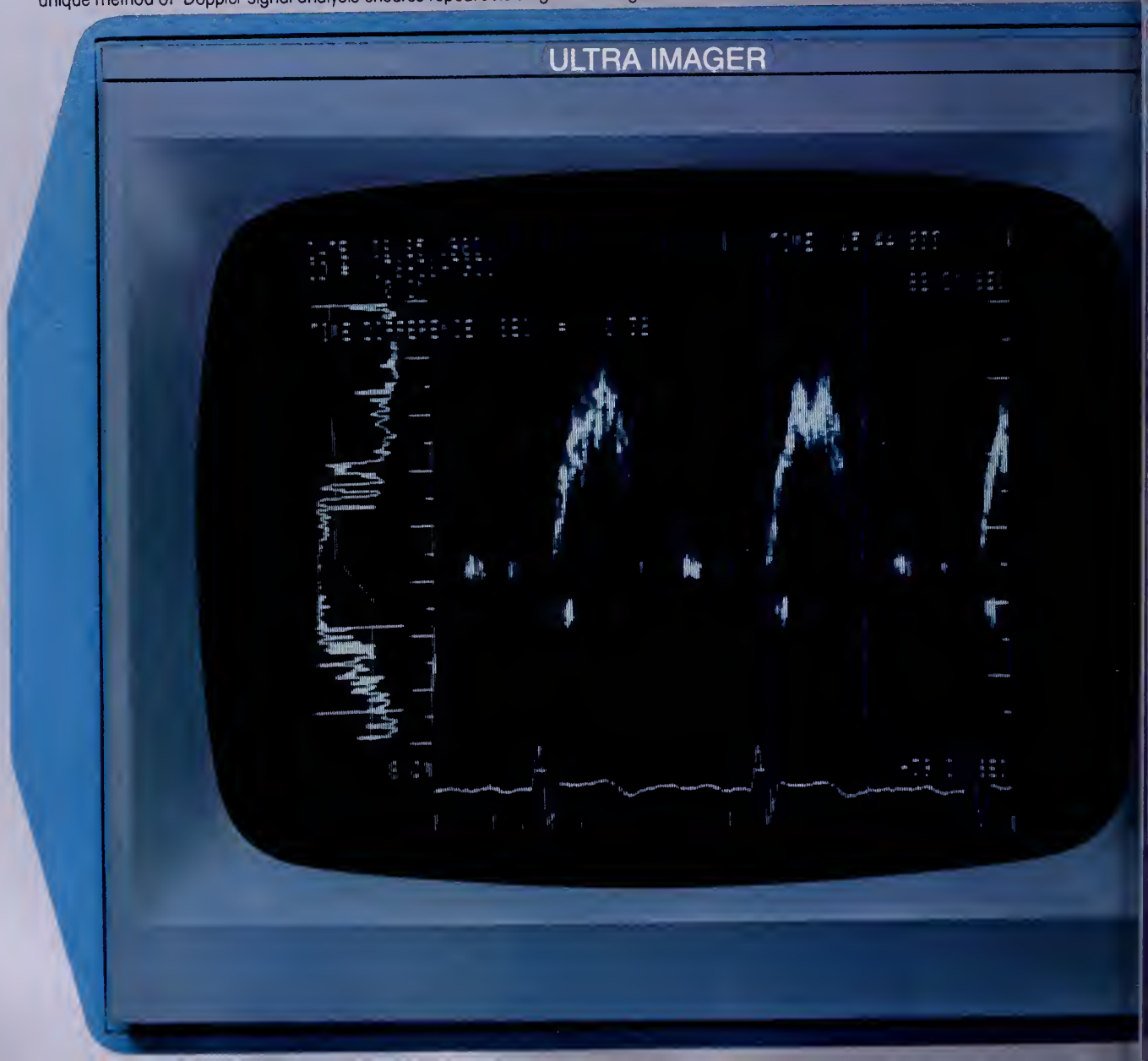
E for M/Honeywell announces the first major advance of the 1980's in echocardiography...

Ultra Imager

The only integrated digital echocardiography system with all three major modalities for complete ultrasound diagnosis:

- **Repeatable Pulsed Doppler**
- **2D Real-time**
- **M-mode**

This pulsed Doppler display is a precise, quantitative representation of a spectrum of blood velocities in the pulmonary artery. The Ultra Imager's unique method of Doppler signal analysis ensures repeatable diagnostic images never before available in any clinical ultrasound system.



versatile imaging stem that offers more gnostic information d greater clinical ity.

Today the key to diagnostic value in an echocardiography system is the availability of accurate and repeatable pulsed Doppler images. The Ultra Imager offers you this plus the complementary imaging capabilities you need to perform cardiac examinations.

Using a sophisticated spectral analysis technique called Fast Fourier Transform (FFT) the Ultra Imager can process Doppler blood velocity data in real time without the need for an operator to calibrate gain and threshold settings. This makes quantitation of blood flow patterns and flow rates throughout the heart a much simpler clinical procedure.

The Ultra Imager's built-in versatility is made possible by a unique, dedicated array processor designed to handle the high-speed computations required for repeatable Doppler imaging. The computing power of this separate processor makes it possible to combine accurate blood velocities with 2D imaging data to provide the essential measurements for determining stroke volume and cardiac output. The Ultra Imager is the only 2D/Doppler System available offering this level of diagnostic versatility.

Honeywell's new LS-8 recorder is a standard system feature. It allows you to make a hard copy of the display with full gray scale reproduction and high resolution. You can select page print or strip chart modes and get crisp, black-on-white records with immediate dry processing.

High quality videotaped images are formatted to allow off-line data analysis on playback images. This storage feature allows both physician and operator to conduct diagnostic reviews when it is most convenient.

The Ultra Imager also provides diagnostic quality physiological signal conditioning. Every system includes an ECG channel and can accommodate optional pulse/phono and respiration channels.

Cost-effectiveness built into the Ultra Imager System

The Ultra Imager offers many cost-effective features that enhance its value to cardiology practice. The mechanical sector scan was selected for the system because it offers superior performance in 2D/Doppler imaging at lower cost. In addition, it will permit ready adaptation to future transducer technologies.

Ease of maintenance is again achieved, along with greater electronic stability, by comprehensive digital processing throughout the system. Integrated design of the Ultra Imager avoids the cabling connections and duplicated components associated with the "stacked box" approach.

The system's digital scan converter (image memory) provides you with non-fade displays and gives you instantaneous freeze-frames in any mode without flickering or fading. These advanced display capabilities facilitate diagnostic review and the measurement and recording of scan data.

The unique Auto-Test feature of the Ultra Imager allows the system to test itself for failures. If a failure exists, an appropriate indicator light signals the source of the failure. This simplifies servicing of the instrument.

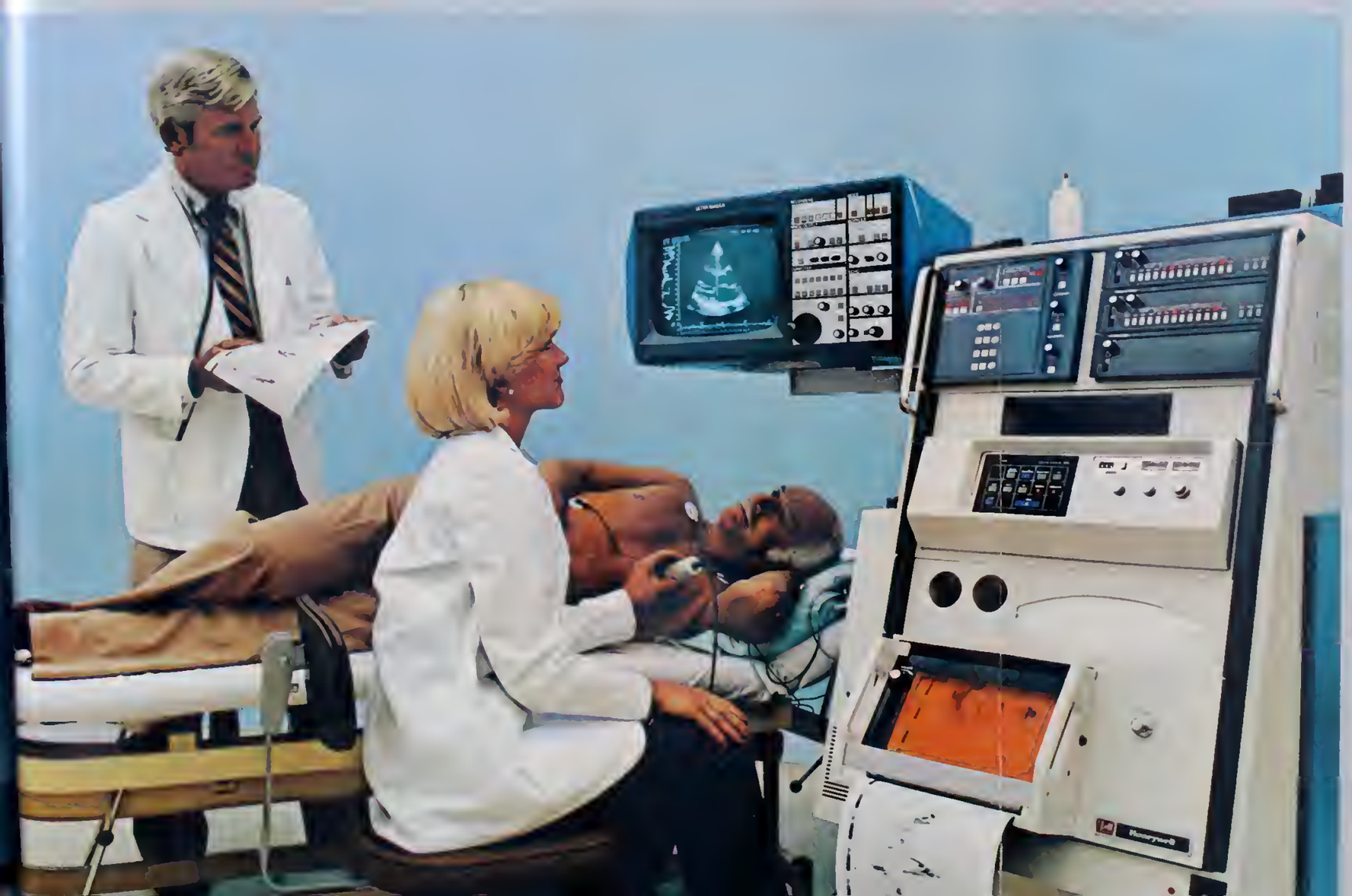
Human engineered with unique operator convenience features

Through careful attention to human engineering details, we have made a sophisticated imaging system easy to operate.

For instance, both the monitor and primary control panel are on a movable gantry that can be positioned near the patient for ease of use and viewing. This makes system controls conveniently accessible to the operator while at the patient's bedside.

The Ultra Imager also includes an audio-visual self-teaching feature which employs the system's videotape recorder to play training programs produced by E for M/ Honeywell. This convenient feature makes staff training a much simpler procedure.

For operator convenience, all displays can be viewed easily even in a daylit room. There is also built-in storage space for gels, tissues, paper and other supplies. Because the cart is compact and easily maneuvered, it can be moved wherever needed.





Operator can position the transducer and be within convenient reach of all necessary scan controls.

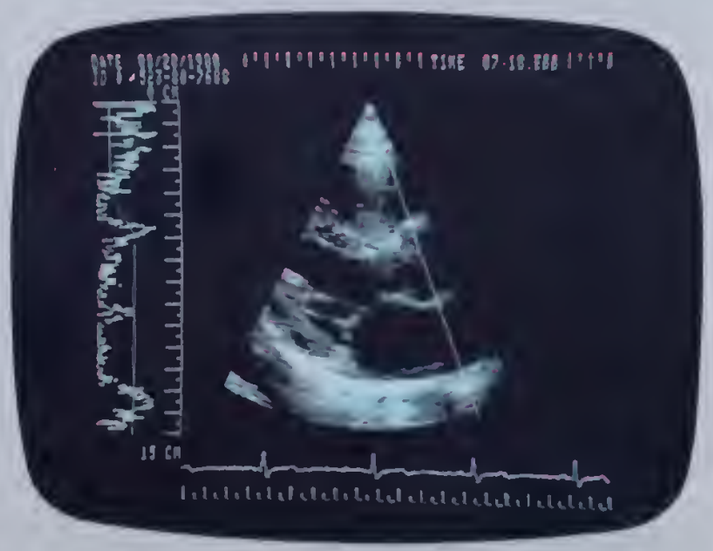


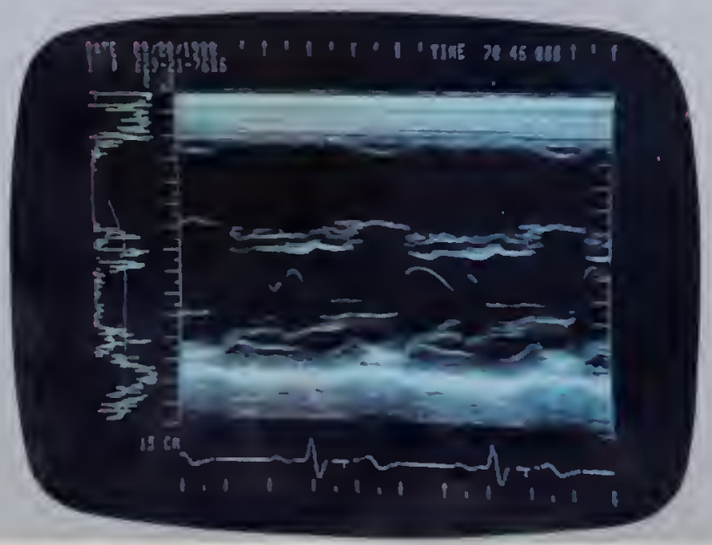
Cardiologist can perform off-line data analysis while listening to voice annotations recorded by the operator.



Audiovisual self-teaching feature facilitates training of new personnel.

E FOR M / Honeywell





Three complementary imaging modalities:

- **Pulsed Doppler**
- **Real-time**
- **M-mode**

On a single video display, the Ultra Imager presents enhanced 2D sector scans, M-mode images or pulsed Doppler data. These three imaging modalities are combined in ways that yield more diagnostic information than ever before. For example, you can change instantly from one mode to another by pressing a button—or use a cursor on a 2D image to determine the placement of an M-mode recording.

The Ultra Imager's multiprocessor system puts cursors and image controls at your fingertips. It also places graphics and alphanumeric messages on the screen to make every examination faster and easier.

The E for M/Honeywell Commitment

E for M/Honeywell has a special commitment to cardiology. Because we've worked with you for over 30 years, we know the kind of service and performance you demand from a medical instrument company. Over the years, we've developed a professional rapport which has led to the development and manufacture of many of the best-engineered, high performance instruments in the healthcare field. The Ultra Imager is one more example of this continuing commitment to excellence.

Service

The Ultra Imager is supported in the field by our own specially trained ultrasound service technicians. Because there are over 40 service locations in the U.S. alone, E for M/Honeywell service is fast and responsive. A toll-free number connected to the Ultra Imager Support Center makes service available 24 hours a day.

The Ultra Imager's Auto-Test feature further minimizes downtime by pinpointing any failures in the system. Now if a service call is needed the technician knows which parts are required to repair the system on-site. In addition, the Repair/Exchange program provides immediate replacement parts for your service technician with the lowest possible board repair cost through the use of Automatic Test Equipment at the factory.

Quality Assurance

The Ultra Imager was designed with reliability and ease of maintenance in mind. "MIL-Spec" reliability analyses were used to evaluate every aspect of the system design. Each subassembly has been thoroughly tested individually and as part of the complete system. And every completed unit is subjected to rigorous temperature cycling so that any marginal components can be replaced in the factory. This means that the system we install for you is in optimum working order.

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Dr. Simons

Robert L. Simons, M.D., of North Miami Beach . . . has been re-elected Treasurer of the American Academy of Facial Plastic and Reconstructive Surgery.

The election came at the Academy's annual meeting at Anaheim, Calif., on September 28. The meeting was attended by more than 600 head and neck plastic surgeons from this country and elsewhere.

A graduate of the University of Pennsylvania Medical School in Philadelphia, Dr. Simons is Assistant Professor of Clinical Otolaryngology at the University of Miami School of Medicine.

The Florida Perinatal Association . . . has recognized the contributions of **Gerold L. Schiebler, M.D.,** toward improving maternal and infant care in Florida. The Association, which is composed primarily of health practitioners concerned with the care of mothers and babies, presented the award to Dr. Schiebler during the seventh annual conference held recently in Orlando.

Dr. Schiebler, Chairman of the University of Florida College of Medicine Department of Pediatrics and former Editor of *The Journal,* was described by the Association as "the person most initially involved in developing the Florida Regionalized Perinatal Intensive Care Program."

Also honored was Sister Carol Keehan, R.N., for her role in establishing the Neonatal Intensive Care Center at Sacred Heart Children's Hospital in Pensacola.

FMA President T. Byron Thames, M.D. . . . has been appointed Clinical Assistant Professor of Comprehensive Medicine at the University of South Florida College of Medicine. Dr. Thames, of Orlando, will assist in the development of an expanded program of industrial medicine and occupational health.

Donald William Goodwin, M.D., of West Palm Beach . . . has recently been admitted to the American College of Radiology.

Richard J. Feinstein, M.D., of Miami . . . has been appointed Editor of *Miami Medicine,* succeeding **Edward W. St. Mary, M.D.,** who resigned after serving several years in the post.

Dr. Feinstein's appointment was made by the Dade County Medical Association Board of Trustees. The new Editor is a practicing dermatologist and a member of the Florida State Board of Medical Examiners and of the DCMA Public Relations Committee.

Ian Phillips, Ph.D. . . . has joined the University of Florida College of Medicine as Professor and Chairman of the Department of Physiology. He succeeds **Dr. Arthur T. Otis,** who stepped down from the chair after 24 years but will continue teaching and research.

Dr. Phillips, who has research interests in hypertension and the effects of peptide hormones on the brain, most recently served as Professor of Physiology and Pharmacology at the University of Iowa.


Dr. Coggins

Wilmer J. Coggins, M.D. . . . has accepted appointment as Dean of the College of Community Health Sciences in Tuscaloosa, Ala. For the past several years he has been Professor of Medicine and Chief of the Division of Rural Health at the University of Florida College of Medicine.

A native of Madison, Dr. Coggins received his M.D. degree from Duke University School of Medicine in 1951. He is a former member and Chairman of the FMA Committee on Rural Health, and last year served as Chairman of the FMA Committee on Public Health.

Principles of Medical Ethics

Preamble:

The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility not only to patients, but also to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.

1. A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.

2. A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception.

3. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.

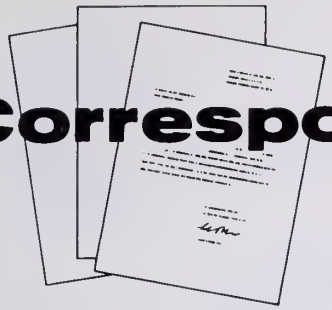
4. A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law.

5. A physician shall continue to study, apply and advance scientific knowledge, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.

6. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services.

7. A physician shall recognize a responsibility to participate in activities contributing to an improved community.

The above Principles of Medical Ethics were adopted at the last meeting of the American Medical Association House of Delegates in July 1980.



Correspondence

PRINCIPLES OF MEDICAL ETHICS

To the Editor: We recently published the new Principles of Medical Ethics as adopted by the American Medical Association House of Delegates. There are no sweeping, resounding changes of the conduct of professionals toward each other that are advocated therein. The principles are a reaffirmation that the learned professions can stipulate what acceptable conduct is anticipated.

We have accepted advertising of an address; the opening or closing of an office and similar changes for the public benefit. We have stated that a colleague who claims credentials for which he is not trained is misleading the public. We have, in other instances, stated that a physician has breached the advertising line to the degree that he is soliciting. Others have been taken to task by their peers for fraud, deceit and misrepresentation in their public announcements. Self aggrandizement does not meet professional standards of conduct.

Southern Bell Telephone Company is a for profit corporation. They sell advertising in the Yellow Pages for their profit. We strongly suggest that you consider the dignity of yourself as an individual, and the historical respect granted to the profession when you are signing your contract with Southern Bell in the next few months.

Phillip A. Caruso, M.D.
President
Broward County Medical Association

PHARMACY INSPECTORS AND SCHEDULE II DRUGS

To the Editor: In the last session of the Florida Legislature I was able to obtain 12 new pharmacy inspectors for the Department of Professional Regulations. This was a compromise piece of legislation since the Triplicate Prescription Bill did not pass. It will be the function of these inspectors to check schedule II prescriptions every three months in each of Florida's 2,300 pharmacies.

Following a meeting with officials from DPR the below listed suggestions would be helpful in reducing the number of illegal overprescribed schedule II prescriptions:

1) Filling in the patient's address on the prescription blank.
2) Requiring the usual standard of medical care to include an adequate patient record prior to either dispensing or prescribing schedule II drugs.
3) Taking all possible measures to protect prescription pads in the physician's office. This, of course, would also include leaving pads in unattended examining rooms.
4) Have a written record either on the patient's chart or a copy of the prescription ordered for the patient attached to the patient's chart.
5) Stop dispensing schedule II drugs in doctor's offices.

Most physicians are probably already practicing up to the standards of these suggestions. Perhaps now with the increased inspections of schedule II prescriptions in pharmacies the small percentage of illegal prescribers will stop this dangerous activity which is so injurious to our children and young adults.

David J. Lehman, M.D.
State Representative, District 97

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Anturane (sulfinpyrazone) Ciba-Geigy Corporation
Erythrocin (erythromycin) Abbott Laboratories

Research and development, the life blood of pharmacotherapeutic progress

The drugs that have contributed so much to modern medicine were the product of long years of expensive research. And tomorrow's drugs depend upon continuation of the research and development going on right now. The cost of that research is one of the things reflected in the price of a brand-name drug. The substitution of a cheaper "generic" drug for a brand-name product may save the patient some money at the prescription counter. However, it threatens the very foundations of modern pharmaceutical research.

The hidden cost of "cheaper" generic drugs

Much of the enthusiasm for generic prescribing is based on a shortsighted view that fails to take such long-term issues into account. While cost is an important factor, pharmaceutical research, the quality of medicine, and future generations of patients must all be considered.

Settling for cheaper drugs today could deprive you and your patients of the drugs they may need tomorrow.

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FMA AUXILIARY

A Special Report on the FMAA Fall Convention

The Florida Medical Association Auxiliary, third largest in the nation, met September 8-10 at the Hyatt House in Sarasota for its Annual Fall Conference and Board Meeting. One hundred 40 auxiliary leaders attended, representing 39 component medical auxiliaries.

The group, led by State President Mrs. Fred Swing, zeroed in on specific problems and community needs and discussed solutions and courses that can be pursued to respond to these needs. "Get into the act!", Mrs. Swing urged the conferees as they addressed the problem of child abuse, and the urgency of dealing with the impaired physician and his family. Group sharing sessions were held on these subjects.

There were also workshop sessions on membership and legislation. The need for the physician's spouse to be concerned with, and alert to political issues affecting the medical practitioner and the profession as a whole was stressed. On hand to lend their legislative expertise were: State Legislation Chairman Mrs. James White; FLAMPAC Representative Mrs. B. D.Epstein; Mrs. Ben Moore from the AMPAC Board; Mr. George Palmer, Manager of FMA's Capital Office; Mr. Russell E. Berge, Manager of FMA's Tampa Office; and Mr. James McCloy, FMA's Legislative Consultant.

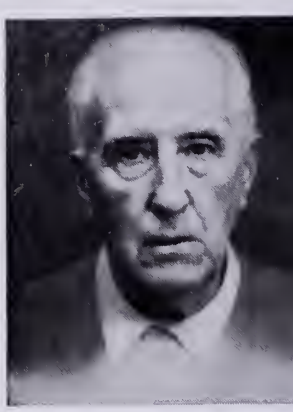
FMA President T. Byron Thames, M.D., special luncheon speaker, conveyed AMA's concern over getting physicians' families to register and vote, and expressed his own concern over getting more physicians to attend the FMA Annual Meeting. He said he hoped Auxilians will also channel some of their efforts into these directions. He also indicated that FMA has budgeted $25,000 to start the Impaired Physicians Program under a committee chaired by Guy Selander, M.D. The Auxiliary's state chairman, Mrs. Frederick Weigand, will sit with this committee.

There were moments of jubilation as the group applauded Auxiliary delegates whose efforts helped pass the Uniform Donor Bill in the State, and who successfully introduced a resolution adopted by the AMAA last July which will now encourage adoption of this bill by the remainder of the states.

The conferees also reported on the Auxiliary's latest project — a statewide talent search. This is an all out effort to identify the Auxiliary's available resources, from state to county levels, with the objective of channeling all these fresh talents, new ideas, energies and enthusiasm into making the Auxiliary relevant, up to date, and an effective, formidable, and vital partner of organized medicine in Florida.

The three-day conference was concluded with a speech by FMA Secretary Robert Windom, M.D.

Mrs. Rod M. Martija
"Beeper" Editor
FMA Auxiliary, Inc.



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Book Reviews

Book Review Editor — F. Norman Vickers, M.D.

Boswell's Clap and Other Essays, Medical Analyses of Literary Men's Afflictions, by William B. Ober, M.D. Price $17.50. Southern Illinois University Press, P.O. Box 3697, Carbondale, Illinois 62901 and Feffer and Simons, Inc., London and Amsterdam. 291 Pages. 1979.

This book might be titled, "Things they didn't teach you in literary class." In 10 chapters, Dr. Ober, a pathologist and literary hobbyist, dissects the lives and writings of some literary greats. In the title article, he traces James Boswell's career as a roue' and cumpulsive diarist. Bosell's compulsive writing made him famous as Samuel Johnson's biographer. Ober traces Boswell's 19 separate attacks of gonorrhea which ultimately lead to death from uremia. Ober considers the poetry of William Carlos Williams in relation to the poet's career as a physician. He also considers the reasons why Chekhov, who filled his works with doctors and medical situation, had ambivalent feelings toward the medical profession.

Thomas Shadwell, who is reputed to have died of an overdose of laudanum, probably died from coronary occlusion.

D. H. Lawrence's writings are discussed in relationship to his physical condition. While writing *Lady Chatterley's Lover,* he was weakened by tuberculosis.

Ober contends that Plato's version of Socrates' death omitted the gruesome details of hemlock poisoning in order to make the tragedy into a neat dramatic event.

Kenneth Dewhurst writing in the "Journal of the History of Medicine" states, "Dr. Ober's microscope brings the psychopathology of his subjects into sharp focus without obliterating his wise field of vision; it is for this reason that these essays, written in a lively and lucid style, deserve a wider audience than physicians and medical historians."

F.N.V.

Doctor Fischer of Geneva (or) The Bomb Party, by Graham Greene, 156 Pages. Price $9.95. Simon and Schuster, New York. 1980.

This novella deals with the capricious and malevolent use of power over others. Set in Switzerland, the story deals with an obscenely rich dentist — inventor, who by virtue of successful patents is wealthy enough to surround himself with fawning toadies.

The protagonist makes a striking contrast to Dr. Fisher. Alfred Jones is a middle-aged widower who supports himself by writing and translating letters for a Swiss chocolate manufacturer. By coincidence, Jones meets Anna-Luise, daughter of Dr. Fischer, thereby being brought into the influence of Dr. Fischer. Jones quickly comes to detest Fischer, "not for his money", but "for his pride, his contempt of the world, and his cruelty". Dr. Fischer is so selfishly in pursuit of his whims that he is unable to attend his daughter's wedding.

Jones, by a chain of circumstances, attends Fischer's "final party". This is designed by the mad doctor to test how far the guests are willing to go, what risks, including death, they are willing to take in pursuit of money. You will have to read the book to learn the ending.

I understand this is not Greene's best book, but it makes for an entertaining evening's reading.

F.N.V.

Books Received

Receipt of the following books is acknowledged.

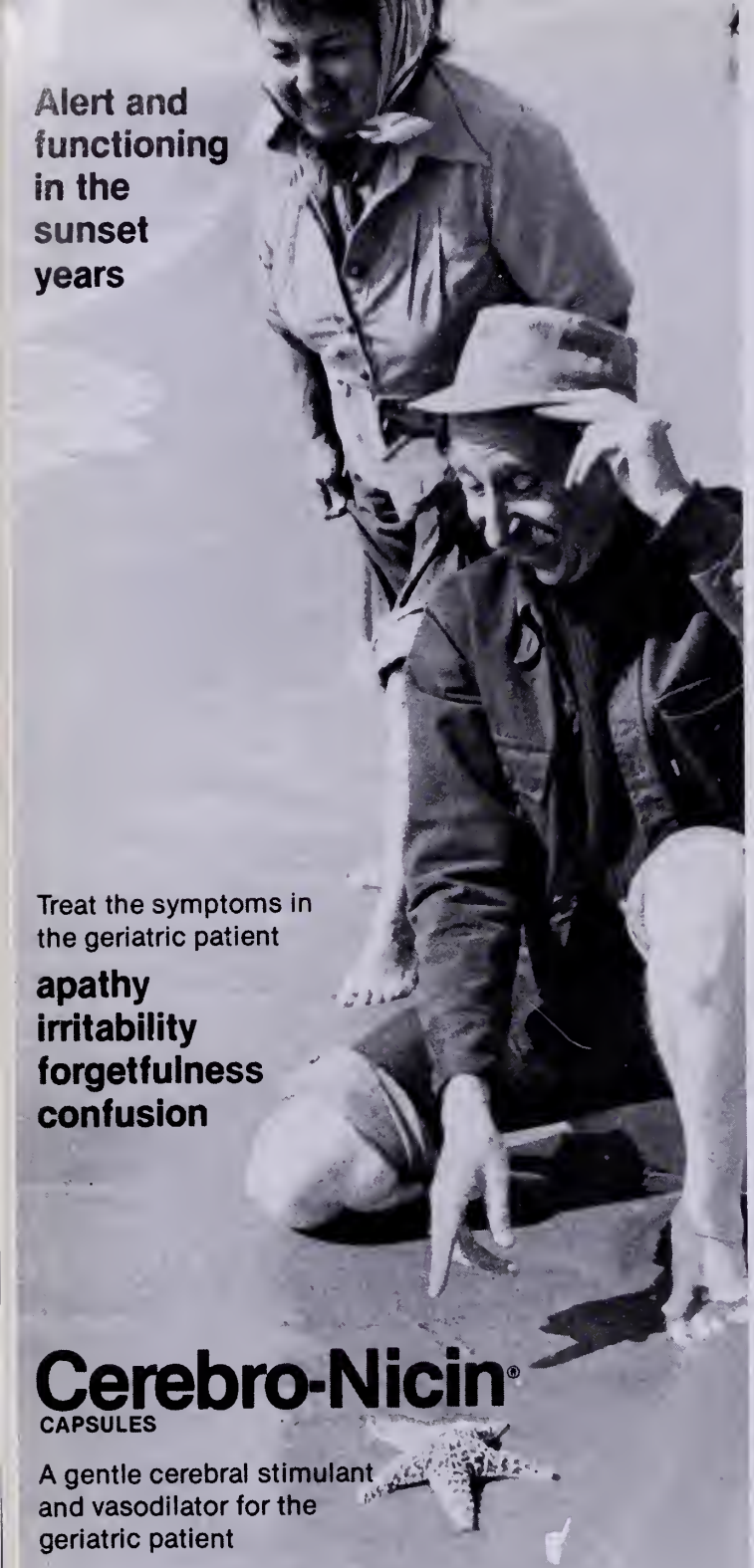
The Chemistry of Human Behavior by Herbert L. Meltzer, Ph.D. 261 Pages. Illustrated. Price $17.95 (cloth). Nelson-Hall Publishers, Chicago, 1979.

Annual Review of Neuroscience with 31 contributing authors. 555 Pages. Annual Reviews, Inc., Palo Alto, California, 1979.

Norethindrone, The First Three Decades edited by Mary Jean Pramik. 100 Pages. Syntex Laboratories, Palo Alto, California, 1978.

The Vitamin Book by Rich Wentzler. 224 Pages. Price $4.95. Doubleday & Company, Inc., New York, 1979.
Company, New York, 1979.

Cooking Creatively for Your Diabetic Child by Caroline Hastings Babington. 224 Pages. Price $8.95. Doubleday & Company, Inc., New York, 1979.



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Clinical Anxiety/Tension in Primary Medicine: Proceedings of a Colloquium, Washington, D.C., Excerpta Medica, Lawrenceville, N.J.

Handbook of Pediatrics by Henry K. Silver, M.D.; C. Henry Kempe, M.D. and Henry B. Bruyn, M.D. 730 Pages. Price $9.50. Lange Medical Publications, Los Altos, California, 1980.

Handbook of Poisoning, Tenth Edition, by Robert H. Dreisback, M.D. 578 Pages. Price $9.50. Lange Medical Publications, Los Altos, California, 1980.

General Ophthalmology, Ninth Edition, by Daniel Vaughan, M.D. and Taylor Asbury. 410 Pages. Price $15.00. Illustrated. Lange Medical Publications, Los Altos, California, 1980.

Controlling the Use of Therapeutic Drugs, An International Comparison, edited by William M. Wardell. 263 Pages. Price $4.75. Illustrated. American Enterprise Institute for Public Policy Research, Washington, D.C., 1978.

Annual Reviews Reprints: Immunology, 1977-1979, compiled by Irving Weissman. 466 pages. Illustrated. Annual Reviews, Palo Alto, California, 1980.

The Diabetic Gourmet, Revised Edition by Angela Bowen, M.D. 193 Pages. Price $10.95. Harper and Row, New York, 1980.

Current Pediatric Diagnosis and Treatment by C. Henry Kempe, M.D., Henry K. Silver, M.D., and Donough O'Brien, M.D. 1122 Pages. Illustrated. Price $20.00. Lange Medical Publications, Los Altos, California, 1980.

Basic First Aid, Second Edition by the American Red Cross. Four volumes, 790 Pages. Price $5.25. Illustrated. Doubleday & Company, Inc., New York, 1980.

Review of Medical Microbiology, 14th Edition by Ernest Jawetz, Ph.D., M.D., Joseph L. Melnick, Ph.D. and Edward A. Adelberg, Ph.D. 593 Pages. Price $14.00. Illustrated. Lange Medical Publications, Los Altos, California, 1980.

Handbook of Obstetrics & Gynecology, Seventh Edition by Ralph C. Benson, M.D. 808 Pages. Price $10.00. Illustrated. Lange Medical Publications, Los Altos, California, 1980.

Breast Self-Examination by Albert R. Milan, M.D. 125 Pages. Paperback. Price $3.50. Workman Publishing Company, New York, 1980.

Handbook of Obstetrics and Gynecology by Ralph C. Benson, M.D. 808 Pages. Paperback. Price $10.00. Lange Medical Publications, Los Altos, California, 1980.

Ceasarian Childbirth, A Handbook for Parents by Christine Coleman Wilson and Wendy Roe Hovey. 297 Pages. Paperback. Price $6.95. Doubleday and Company, Inc., New York, 1980.

Directory of Pathology Training Programs, 1981-1982. 480 Pages. Paperback. Price $25.00. The Intersociety Committee on Pathology Information, Inc., Bethesda, Maryland, 1980.

Basic Histology by Luis C. Junqueira, M.D. and Jose Carneiro, M.D. 504 Pages. Paperback. Price $15.50. Lange Medical Publications, Los Altos, California, 1980.

Emergency Handbook by Peter Arnold with Edward L. Pendagast Jr., M.D. 250 Pages. Price $11.95. Doubleday & Company, New York, 1980.

Whole Again by Lee Whipple. 232 Pages. Price $9.95. Caroline House Publishers, Inc., Ottawa, Illinois, 1980.

Footnotes by Michelle Arnot. 164 Pages. Paper. Illustrated. Price $5.95. Doubleday & Company, Inc., New York, 1980.

Microbial Diseases — Notes, Reports, Summaries, Trends compiled by Carl W. May. 322 Pages. Paperback. Illustrated. William Kaufmann, Inc., Los Altos, California, 1980.

Sound Sleep by Quentin R. Regestein, M.D. 208 Pages. Illustrated. Price $10.95. Simon and Schuster, New York, 1980.

Current Obstetric and Gynecologic Diagnosis and Treatment by Ralph C. Benson, M.D. 1001 Pages. Illustrated. Paper. Price $21.00. Lange Medical Publications, Los Altos, California, 1980.

Consumer's Guide to Cosmetics by Tom Conry. 376 Pages. Illustrated. Paper. Price $3.95. Doubleday & Company, Inc., New York, 1980.

Mesmerism, A Translation of the Original Medical and Scientific Writings of F. A. Mesmer, M.D. 180 Pages. Price $11.50. William Kaufmann, Inc., Los Altos, California, 1980.

The Human Patient by Naomi Remen, M.D. 264 Pages. Price $10.95. Anchor Press, New York, 1980.

The Doctors' Case Against the Pill by Barbara Seaman. 239 Pages. Paper. Price $6.50. Doubleday & Company, Inc., New York, 1980.

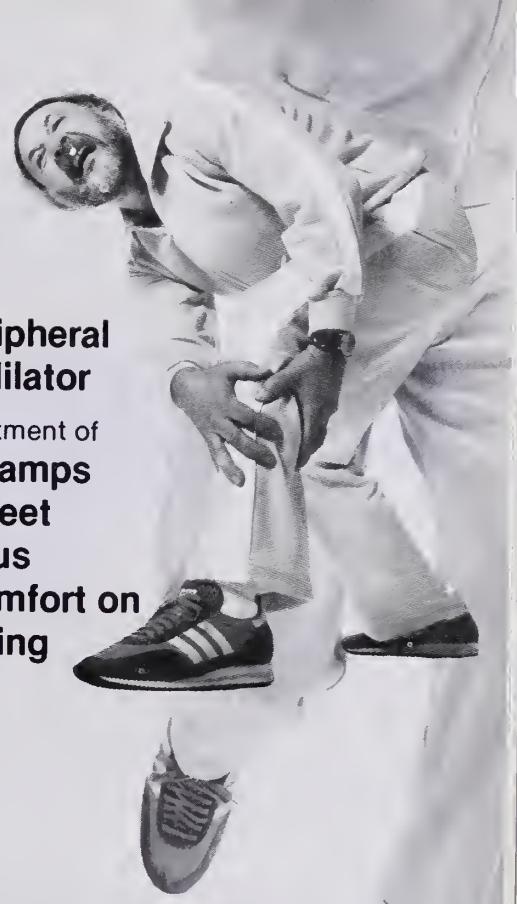
Every Woman's Health, The Complete Guide to Mind and Body edited by D. S. Thompson, M.D. 776 Pages. Illustrated. Price $19.95. Doubleday & Company, Inc., New York, 1980.

Sex by Prescription by Thomas Szasz. 198 Pages. Price $10.95. Doubleday & Company, Inc., New York, 1980.

Dangerous Marine Animals That Bite, Sting, Shock, Are Non-Edible by Bruce W. Halstead, M.D. 208 Pages. Illustrated. Price $15.00. Cornell Maritime Press, Inc., Centreville, Maryland, 1980.

Atlas of Bedside Procedures edited by Thomas J. Vander Salm, M.D. 408 Pages. Illustrated. Price $18.95. Little Brown and Company, Boston Massachusetts, 1980.

Legal Rights of Asbestos Exposure Victims by Roman M. Silberfeld and Richard L. Hecht. 14 Pages. Silberfeld and Hecht, Los Angeles, 1980.



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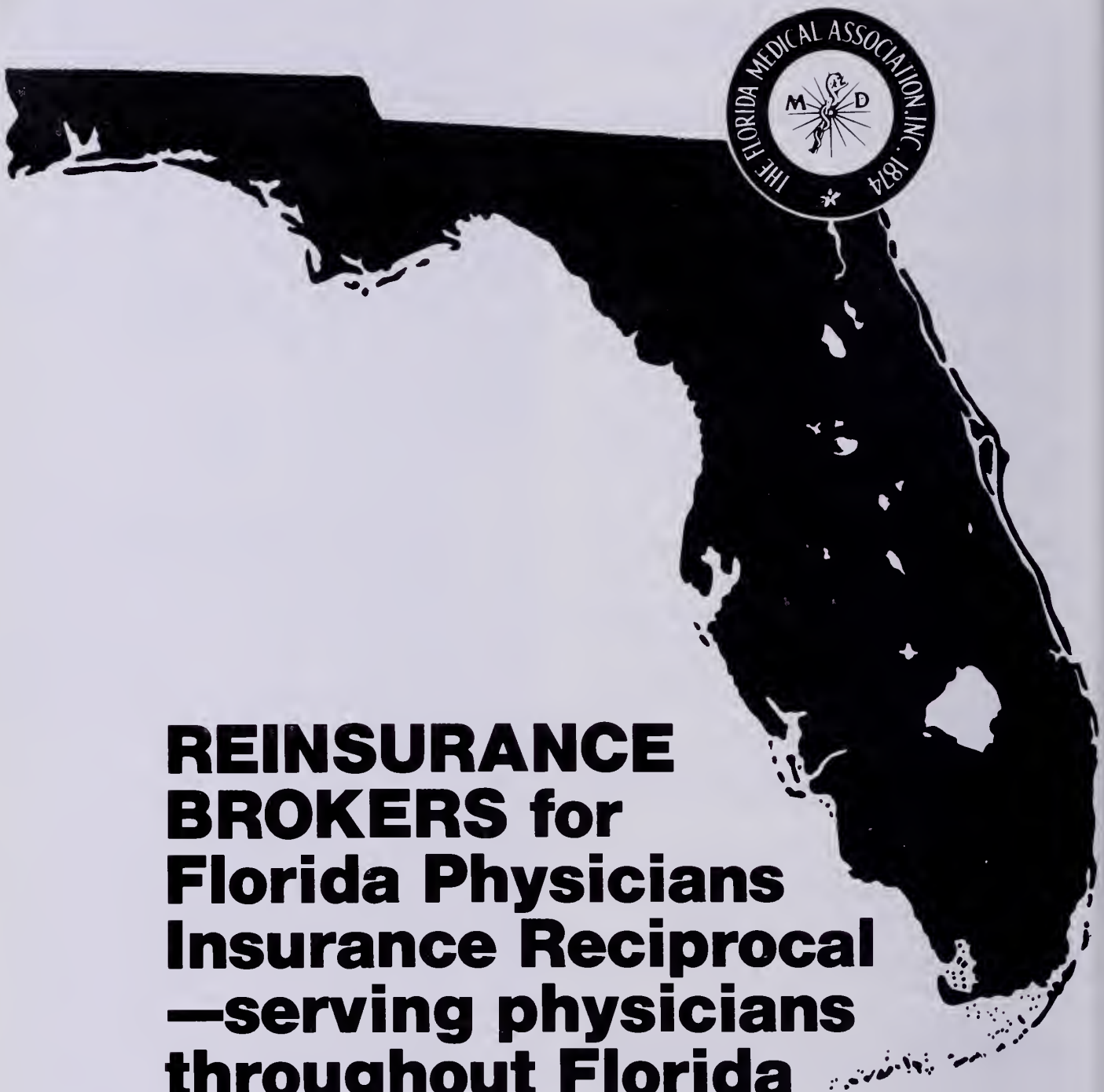
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MEETINGS

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DECEMBER

Basic Life Support (CPR), Dec. 2, University Community Hospital Conference Room, Tampa. For information: John E. Perchalski, M.D., 10320 North 56th Street, Suite G, Temple Terrace 33617.

Laparoscopy Techniques and Therapeutic Techniques, Dec. 3-5, Contemporary Resort Hotel, Walt Disney World, Lake Buena Vista. For information: H. Worth Boyce Jr., M.D., USF Medical Center, Box 19, 12901 North 30th Street, Tampa 33612.

The 6th Annual Course in Behavioral Neurology, Dec. 4-6, Daytona Hilton, Daytona Beach. For information: Edward Valenstein, M.D., Box J-236, J.H.M. Health Center, Gainesville 32610.

Florida Obstetric and Gynecologic Society Annual Scientific Session, Dec. 5-7, Grenelefe Golf and Tennis Resort, Haines City. For information: Eric Geiger, M.D., P.O. Box 151, Pensacola 32591.

Hypertension Rounds, Dec. 10, The Deauville Hotel, Miami Beach. For information: Barry J. Materson, M.D., 1201 N.W. 16th Street, Miami 33125.

Practical Aspects of the Diagnosis and Management of Ventricular Arrhythmias, Dec. 10, Don CeSar Beach Resort Hotel, St. Petersburg Beach. For information: Bill Rockwood, Program Coordinator, Box J-233, Gainesville 32610.

Update on Medicine in Florida, Dec. 10, Peace River Country Club, Bartow. For information: Henry McIntosh, M.D., P.O. Box 927, Lakeland 33802.

Seminars in Family Practice, Dec. 11-13, Sundial Resort, Sanibel Island. For information: Dennis D. Frink, D.O., 753 Pondella Road, North Ft. Myers 33903.

Neuro-Ophthalmology Course, Dec. 11-13, Key Biscayne Hotel, Key Biscayne. For information: Division of CME (D23-3), University of Miami School of Medicine, P.O. Box 016960, Miami 33101.

Rehabilitation of Limb Function in Paralytic Disorders, Dec. 11-13, Sheraton Bal Harbour, Bal Harbour. For information: Division of CME (D23-3), University of Miami School of Medicine, P.O. Box 016960, Miami 33101.

JANUARY

25th Annual Cardiovascular Seminar, Jan. 9-10, Sarasota-Longboat Key Holiday Inn, Longboat Key. For information: Mr. E. Jerry Eatman, Executive Director, American Heart Association, Suncoast Chapter, Inc., Box 12407, St. Petersburg 33733.

IV Annual Review in Oral Pathology, Jan. 12-16, UM/Jackson Memorial Hospital/Mailman Center. For information: Division of CME, University of Miami School of Medicine, Box 016960, Miami 33101.

Neurological Update 1981, Jan. 14-18, Eden Roc Hotel, Miami Beach. For information: Division of CME, University of Miami School of Medicine, Box 016960, Miami 33101.

3rd Annual Walt Disney World Pulmonary Wintercourse, Jan. 15-18, Dutch Inn Resort Hotel, Walt Disney World, Lake Buena Vista. For information: Asher Marks, M.D., P.O. Box 8127, Jacksonville 32211.

16th Annual Pediatric Postgraduate Course, "Continuing Education in Pediatrics — 1981", Diplomat Resorts, Hollywood Beach. For information: Dr. Donald H. Altman, Pediatric Postgraduate Course, Variety Children's Hospital, 6125 S.W. 31st, Miami 33155.

13th Annual Postgraduate Seminar in Pediatric and Adult Urology, Jan. 21-24, Konover Hotel, Miami Beach. For information: Victor Politano, M.D., 6614 Miami Lakes Drive, East, Miami Lakes 33014.

8th Annual Symposium in Pediatric Nephrology: Current Concepts in Diagnosis and Management, Jan. 25-29, Sheraton-Bal Harbour, Bal Harbour. For information: Jose Strauss, M.D., Division of Pediatric Nephrology (R-131), Box 016960, Miami 33101.

19th Annual Seminar "Imageology 1981", Jan. 25-30, Sheraton Bal Harbour, Miami Beach. For information: Lucy R. Kelley, c/o Miami Seminars, Box 343762, Coral Gables 33134.

Personality Adaptation Theory Used Working With Children and Adolescents, Jan. 30, Coronado Beach Resort, Fort Walton Beach. For information: John S. Waldo, A.C.S.W., 203 Beachview Drive, Ft. Walton Beach 32548.

2nd Annual Seminar "Practical Approaches to Diagnostic Problems in Radiology", Jan. 30-Feb. 2, Dutch Inn, Lake Buena Vista. For information: Lucy R. Kelley, c/o Miami Seminars, Box 343762, Coral Gables 33134.

Florida Society of Pathologists Annual Slide Seminar, Jan. 31-Feb. 1, Contemporary Building (Disney World), Lake Buena Vista. For information: C. F. McConnell, M.D., 5151 N. Ninth Avenue, Pensacola 32504.

FEBRUARY

6th Annual Review and Recent Practical Advances in Pathology, Feb. 1-6, Sheraton Bal Harbour, Bal Harbour. For information: Division of CME, University of Miami School of Medicine, Box 016960, Miami 33101.

Florida Mid-Winter Seminar in Ophthalmology, Feb. 2-5, Doral Beach Hotel, Miami Beach. For information: Division of CME, University of Miami School of Medicine, Box 016960, Miami 33101.

Cardiology at Walt Disney World, Feb. 5-8, Contemporary Resort Hotel, Lake Buena Vista. For information: Harold L. Greenberg, M.D., c/o AHA, Central Florida, P.O. Box 6665, Orlando 32853.

Florida Mid-Winter Seminar in Otolaryngology, Feb. 6-8, Doral Beach Hotel, Miami Beach. For information: Division of CME, University of Miami School of Medicine, Box 016960, Miami 33101.

John T. Dickinson Annual Symposium: Advanced Facial Plastic and Reconstructive Surgery, Feb. 6-8, Holiday Inn Oceanside, Vero Beach. For information: Facial Surgery Symposium, Ferdinard F. Becker, M.D., 777 37th Street, Suite C-101, Vero Beach 32960.

1981 Update in OB/GYN, Feb. 9-11, Disney World, Lake Buena Vista. For information: Frank Riggall, M.D., Department of OB/GYN, Box J-294, University of Florida College of Medicine, Gainesville 32610.

Conference on the Beach, 2nd Annual Family Practice Update, Feb. 16-21, Daytona Hilton, Daytona Beach. For information: Richard W. Dodd, M.D., Halifax Hospital Medical Center, Box 1990 Daytona Beach 32015.

Florida Symposium on Micronutrients in Human Nutrition, Feb. 17-18, University of Florida, Gainesville. For information: James R. Kirk, Chairman, Food Science and Human Nutrition Department, University of Florida, Gainesville 32611.

Medical Update 1981, Feb. 18-20, Education Center, South Miami Hospital, South Miami. For information: Leonard Zwerling, M.D., c/o Continuing Education, South Miami Hospital, 7400 S.W. 62nd Avenue, South Miami 33143.

Stress and Chemical Dependency — Strategies for the 80's, Feb. 19-22, The Breakers, Palm Beach. For information: Jose Almeida, M.D., Medical Director, Daryl Kosloske, Executive Director, 1014 N. Olive Avenue, West Palm Beach 33401.

Teaching Conference in Clinical Cardiology, Feb. 25-28, Sheraton Bal Harbour, Bal Harbour. For information: Division of CME, University of Miami School of Medicine, Box 016960, Miami 33101.

Internal Medicine 1981 (16th Annual Postgraduate Course), Feb. 28-Mar. 6, Sheraton Bal Harbour, Bal Harbour. For information: Division of CME, University of Miami School of Medicine, Box 016960, Miami 33101.

MARCH

Being an Effective Clinical Teacher, Mar. 2-6, Sheraton Bal Harbour, Bal Harbour. For information: Division of CME, University of Miami School of Medicine, Box 016960, Miami 33101.

Comprehensive Review in Basic Neurology for Psychiatrists and Generalists, Mar. 2-6, Konover Hotel, Miami Beach. For information: Division of CME, University of Miami School of Medicine, Box 016960, Miami 33101.

Developmental Disabilities and Pediatric Practice, Mar. 5-7, Sheraton and Sand-Key Hotel, Clearwater Beach. For information: Mary G. Tenne, AAP, P.O. Box 1034, Evanston, Illinois 60204.

Problems in Rheumatology, Mar. 11-14, Don CeSar Beach Resort Hotel, St. Petersburg Beach. For information: Bernard F. Germain, M.D., Assistant Professor of Medicine, Director, Division of Rheumatology, Box 19, University of South Florida College of Medicine, 12901 North 30th Street, Tampa 33612.

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PULMONARY INTERNIST, ABIM, University trained all phases of pulmonary medicine, seeks practice position, available July 1981. Reply Clifford Benezra, M.D., 15911 Godwin Court, Fountain Valley, California 92708. (714) 775-0142.

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Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register,* 37:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

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Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

Pneumocystis carinii pneumonitis: Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets,* each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. *Tablets,* each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. *Oral suspension,* containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

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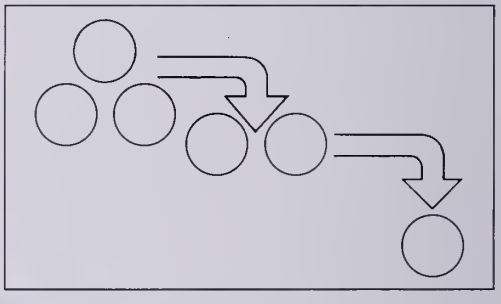
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Tapers naturally; complements gradual dosage reduction at discontinuation When any psychoactive medication is discontinued, it is good medical practice to gradually reduce the dosage. From your own experience you know this is rarely necessary after a short course of Valium therapy, but for patients on extended therapy, gradual reduction of dosage is advisable. This regimen, along with the self-tapering feature of Valium, provides a smooth transition to independent coping.

*Sellers EM: *Drug Metab Rev* 8(1):5-11, 1978



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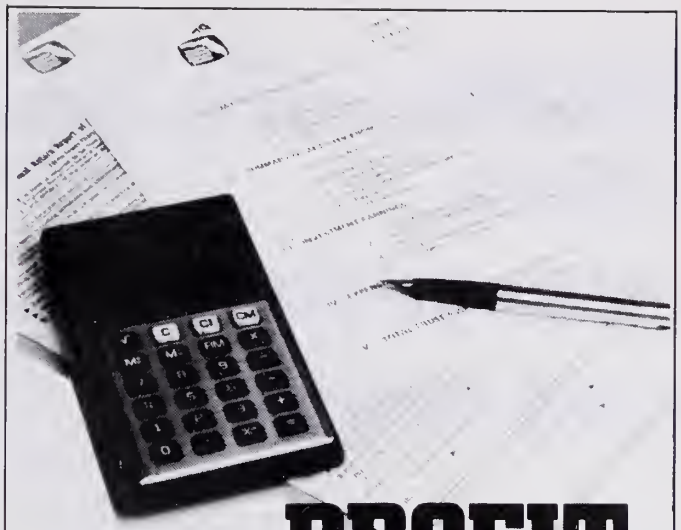
Before prescribing, please see summary of product information on next page.

ROCHE®

Valium® IV
diazepam/Roche

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety, symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal, adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy)
The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.
Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.
***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.

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President's Page

The Season Is Upon Us

This is the time of year when we pause to give thanks for our blessings. We set aside a day to commemorate the fortune that has smiled upon us as a nation and individually. I wonder how many truly reflected on these blessings on Thanksgiving.

This is a time of trial for our country. The question of our pre-eminence among nations in production, military strength, and economy has been raised by many. This is a time of trial for our profession. We are members of diverse specialty organizations with decreasing numbers belonging to our largest national organization. We are beset by government planners who decry the increasing costs of medical care and the maldistribution of physicians and yet fuel the fire of inflation by their increased regulations. They insist on continuing medical education for physicians but encourage the production of increasing numbers of physician extenders with less education to care for the medical needs of our nation.

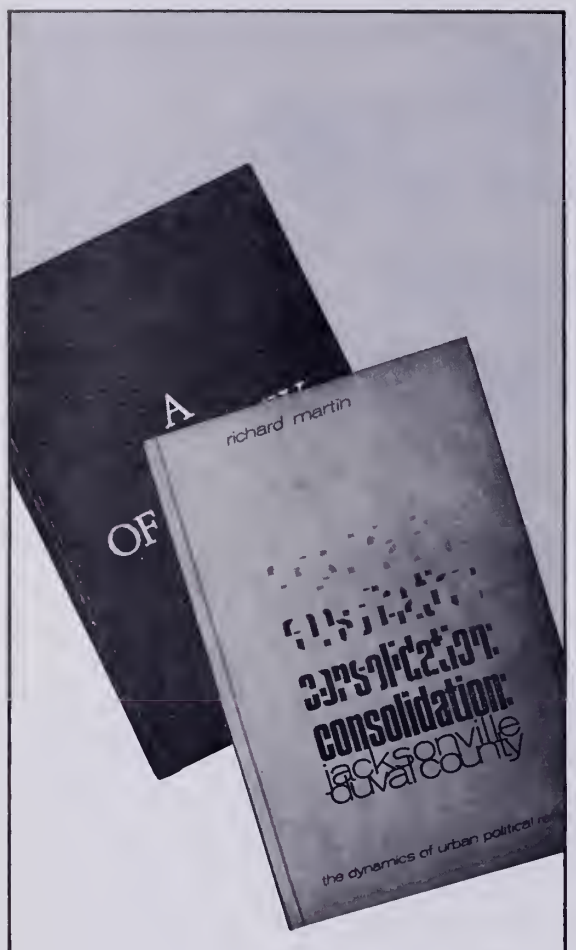
Despite all of these and many other problems not mentioned, we should pause and give thanks that we can still practice medicine in whatever community we wish and determine, to a large extent, how we shall practice and in what specialty. Inroads are being made daily on our ability to continue private practice. We must remain diligent and active in our efforts to maintain our heritage in the same spirit those who came before us carried out and preserved our freedoms.

This is also the season to celebrate the birth of Christ. Whatever our religion, the world has recognized the birth of this great teacher of man. It is a time when families gather and, hopefully, strengthen the ties that bind them together. Much has been written about the loss of family unity in America today. Many of our problems as a nation have been blamed on this loss. The feeling of foregiveness and peace and tranquility that comes with the Christmas season gives us a chance to renew the bond of affection that should exist in every family. It also helps us to renew our faith and strength and to prepare for the winter that comes with the season.

This season as you gather with your family, may the blessings of the Christ child be with you and yours. May you draw added strength to withstand the rigors of another season from One who suffered above all. Yet for all the suffering He remained dedicated to His goal and constantly worked toward its completion with a purity of spirit which we can only strive to emulate. If the goals we seek are pure and serve our patients and their health needs and not our own personal gains we will prevail. "If God be with us who can stand against us"?

May all of us from the Florida Medical Association share this time of thanksgiving and joy of the holiday season with our families, our friends and our patients.

T. Byron Thomas MD



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CYCLAPEN®-W (cyclacillin)

Indications
Cyclacillin has less in vitro activity than other drugs in the ampicillin class and its use should be confined to these indications: Treatment of the following infections:

RESPIRATORY TRACT
- Tonsillitis and pharyngitis caused by Group A beta-hemolytic streptococci
- Bronchitis and pneumonia caused by S. pneumoniae (formerly D. pneumoniae)
- Otitis media caused by *S. pneumoniae* (formerly *D. pneumoniae*) and *H. influenzae*
- Acute exacerbation of chronic bronchitis caused by *H. influenzae**

*Though clinical improvement has been shown, bacteriologic cures cannot be expected in all patients with chronic respiratory disease due to *H. influenzae*.

SKIN AND SKIN STRUCTURES (integumentory) infections caused by Group A beta-hemolytic streptococci and staphylococci, nonpenicillinase producers.

URINARY TRACT INFECTIONS caused by *E. coli* and *P. mirabilis*. (This drug should not be used in any *E. coli* and *P. mirabilis* infections other than urinary tract.)

NOTE: Perform cultures and susceptibility tests initially and during treatment to monitor effectiveness of therapy and susceptibility of bacteria. Therapy may be instituted prior to results of sensitivity testing.

Contraindications Contraindicated in individuals with history of an allergic reaction to penicillins.

Warnings Cyclacillin should only be prescribed for the indications listed herein.

Cyclacillin has less *in vitro* activity than other drugs of the ampicillin class. However, clinical trials demonstrated it is efficacious for recommended indications.

Serious and occasional fatal hypersensitivity (anaphylactoid) reactions have been reported in patients on penicillin. Although anaphylaxis is more frequent following parenteral use, it has occurred in patients on oral penicillins. These reactions are more apt to occur in individuals with history of sensitivity to multiple allergens. There are reports of patients with history of penicillin hypersensitivity reactions who experienced severe hypersensitivity reactions when treated with a cephalosporin. Before penicillin therapy, carefully inquire about previous hypersensitivity reactions to penicillins, cephalosporins and other allergens. If allergic reaction occurs, discontinue drug and initiate appropriate therapy. Serious anaphylactoid reactions require immediate emergency treatment with epinephrine. Oxygen, I.V. steroids, airway management, including intubation, should also be administered as indicated.

Precautions Prolonged use of antibiotics may promote overgrowth of nonsusceptible organisms. If superinfection occurs, take appropriate measures.

PREGNANCY: Pregnancy Category B. Reproduction studies performed in mice and rats at doses up to 10 times the human dose revealed no evidence of impaired fertility or harm to the fetus due to cyclacillin. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, use this drug during pregnancy only if clearly needed.

NURSING MOTHERS: It is not known whether this drug is excreted in human milk. Because many drugs are, exercise caution when cyclacillin is given to a nursing woman.

Adverse Reactions Oral cyclacillin is generally well tolerated. As with other penicillins, untoward sensitivity reactions are likely, particularly in those who previously demonstrated penicillin hypersensitivity or with history of allergy, asthma, hay fever, or urticaria. Adverse reactions reported with cyclacillin: diarrhea (in approximately 1 out of 20 patients treated), nausea and vomiting (in approximately 1 in 50), and skin rash (in approximately 1 in 60). Isolated instances of headache, dizziness, abdominal pain, vaginitis, and urticaria have been reported. (See WARNINGS) Other less frequent adverse reactions which may occur and are reported with other penicillins are anemia, thrombocytopenia, thrombocytopenic purpura, leukopenia, neutropenia and eosinophilia. These reactions are usually reversible on discontinuation of therapy.

As with other semisynthetic penicillins, SGOT elevations have been reported.

As with antibiotic therapy generally, continue treatment at least 48 to 72 hours after patient becomes asymptomatic or until bacterial eradication is evidenced. In Group A beta-hemolytic streptococcal infections, at least 10 days' treatment is recommended to guard against risk of rheumatic fever or glomerulonephritis. In chronic urinary tract infection, frequent bacterialogic and clinical appraisal is necessary during therapy and possibly for several months after. Persistent infection may require treatment for several weeks.

Cyclacillin is not indicated in children under 2 months of age.

Patients with Renal Failure Cyclacillin may be safely administered to patients with reduced renal function. Due to prolonged serum half-life, patients with various degrees of renal impairment may require change in dosage level (see DOSAGE AND ADMINISTRATION in package insert).

Dosage (Give in equally spaced doses)

INFECTION	ADULTS	CHILDREN*
Respiratory Tract		
Tonsillitis & Pharyngitis	250 mg q.i.d.	body weight < 20 kg (44 lbs) 125 mg q.i.d. body weight > 20 kg (44 lbs) 250 mg q.i.d.
Branchitis and Pneumania		
Mild or Moderate Infections	250 mg q.i.d	50 mg/kg/day q.i.d.
Chronic Infections	500 mg q.i.d.	100 mg/kg/day q.i.d.
Otitis Media	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day†
Skin & Skin Structures	250 mg to 500 mg q.i.d.†	50 to 100 mg/kg/day†
Urinary Tract	500 mg q.i.d.	100 mg/kg/day

*Dosage should not result in a dose higher than that for adults.
†depending on severity

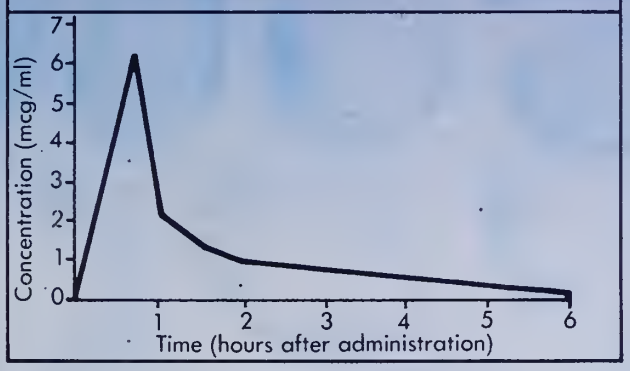
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Philadelphia, Pa 19101

Half the dose is absorbed in 9 minutes!

compared to 32 minutes for ampicillin.*



Mean blood levels in mcg/ml after 250 mg cyclacillin single oral dose



- Rapid, virtually complete absorption from GI tract
- Exceptionally high peak blood levels – 3 times greater than ampicillin (Clinical efficacy may not always correlate with blood levels.)
- Rapidly excreted unchanged in urine – 1½ times faster than ampicillin

*Based on T^{a} ½ values for oral doses of 500 mg cyclacillin tablet and 500 mg ampicillin capsule. Data on file, Wyeth Laboratories.

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Fewer episodes of diarrhea and rash than with ampicillin in studies to date.

Efficacy proven in the treatment of bronchitis, pneumonia, and upper respiratory infections.†

In 117 patients, 73 with bronchitis/pneumonia caused by *S. pneumoniae* and 44 with streptococcal sore throat caused by Group A beta-hemolytic streptococcus, CYCLAPEN®-W achieved a clinical response rate of 100%! Bacterial eradication was 95% and 86% respectively.

†Due to susceptible organisms.

See important information on facing page.

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(cyclacillin) 250 and 500 mg Tablets
125 and 250 mg per 5 ml Suspension

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The "Florida Symposium on Micronutrients in Human Nutrition" presented by the Institute of Food and Agricultural Sciences of the University of Florida will be held February 17 and 18, 1981 in the J. Wayne Reitz Union, University of Florida Campus.

GUEST SPEAKERS

GEORGE H. BEATON, PH.D.
Professor and Chairman
Dept. of Nutrition and Food Science
Faculty of Medicine
University of Toronto
Toronto, Ontario, Canada

JAMES D. COOK, M.D.
Phillips Professor of Medicine
Kansas University Medical Center
Kansas City, Kansas

GARY W. EVANS, PH.D.
Research Chemist
Human Nutrition Laboratory
U.S.D.A., SEA
Grand Forks, North Dakota

KENNETH M. HAMBRIDGE, M.D.
Professor of Pediatrics
Univ. of Colorado Medical Center
Denver, Colorado

VICTOR D. HERBERT, M.D.
Professor of Medicine
SUNY Downstate Medical Center
Bronx, New York

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University of California
Davis, California

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Professor of Nutrition
Dept. of Foods and Nutrition
Purdue University
West Lafayette, Indiana

LAWRENCE LUMENG, M.D.
Associate Professor of Medicine
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Indianapolis, Indiana

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For further information: Dr. James R. Kirk, Food Science and Human Nutrition Department, University of Florida, Gainesville, FL 32611.

This course may be counted toward meeting the FMA CME requirement for 13 hours of FMA Mandatory Credit.

Editorial

Christmas 1980

In a world of nations whose enlarging military arsenals support the fear and greed of their leaders; in a world where morals and traditional values are on trial; and in a world whose entire face has been transformed by a multiplicity of man made laws and machines, there is approaching a season when wanderers and exiles think longingly of home, when scattered members of far flung families plan to reunite and friends and strangers purchase gifts for one another. So too, kind thoughts find lodging in the hardest hearts, longing for purity is born in minds unclean, and the lonely and labouring hear the angels sing.

Even to those who deny the divinity of the Babe whose birthday we commemorate, there is this agreement that the Christmas theme of giving and friendship for all is the age-old longing of mankind groping for a better way of life, as the great pendulum of public opinion quietly swings to sweep away sterile bitterness among friends, alienations of families without due cause and shrill hostility between races. As the years roll by, hopefully, the world grows less cruel, for with enlightenment there comes understanding, then friendship and finally, peace.

Christmas, more than fancy gifts, tinsel, brightly colored lights or elaborate decorations has to do with people, for above all the materialism, Christmas is love for little children, compassion for the sick, as well as respect and dignity for the aged. And in every new baby's cry is generated the hope that the spirit of Christmas will be with us forever and ever.

To some, Christmas a festival of commercialism, is a time for general irrationality, when on one day of the year, everything that's been wrong can be put right. Yet the lesson to learn is not that the richest material environment outside each of us has the power to create a fuller or happier life, for nothing outside us can do this, if a spiritual reservoir is not constructed and sustained inside. Rather than take the magic out of Christmas, must we remove the self deception out of ourselves, for to serve others and to be indispensable somewhere, is the purpose of life and the theme of Christmas.

As wise men still search for Him, so may the truths of the Holy Babe this Christmas, knocking at the hearts of men and women the world over, enter into each of our lives, giving us the grace to bow ourselves to others' needs, letting our ears hear the cry of the needy and our hearts feel the love of the unlovely. Healing the wounds of misunderstanding, jealousy and regret, may the gentle spirit of the Christmas message touch and enrich our lives through every day of the New Year.

Clyde M. Collins, M.D.
Associate Editor
Jacksonville



The primary beneficiaries of ORAL HYDERGINE® TABLETS, 1 mg (1 tab t.i.d.)

Each 1 mg Hydergine tablet contains dihydroergocornine mesylate 0.333 mg, dihydroergocristine mesylate 0.333 mg, and dihydroergocryptine (dihydro-alpha-ergocryptine and dihydro-beta-ergocryptine in the proportion of 2:1) mesylate 0.333 mg, representing a total of 1 mg.

They're in their late sixties, the beneficiaries of more liberal retirement laws and more enlightened attitudes toward the elderly. They're leading socially productive lives. But recently, without any clear cause, they had each begun to experience mild episodes of symptoms such as confusion, mood-depression, and dizziness. Their ability to function could have been jeopardized. That's when they became the beneficiaries of oral Hydergine therapy.



The still-functioning geriatric can benefit from Hydergine treatment

It is quite common for cognitive and emotional symptoms of deterioration to manifest gradually in the elderly. During this early stage, such symptoms are mild and more amenable to treatment. It is at this stage that Hydergine therapy has proved most effective. Patients tend to respond better, and with symptoms effectively relieved—or at least their progression retarded—the ability to function can be maintained.

Oral Hydergine tablets promote better patient compliance

Compared with the sublingual form, dosage administration is easier, with less need for supervision.

Contraindications: Hypersensitivity to the drug.
Precautions: *Because the target symptoms are of unknown etiology, careful diagnosis should be attempted before prescribing Hydergine tablets and sublingual tablets.*
Adverse Reactions: Serious side effects have not been found. Some sublingual irritation, transient nausea, and gastric disturbances have been reported. Hydergine tablets and sublingual tablets do not possess the vasoconstrictor properties of natural ergot alkaloids.
Dosage and Administration: 1 mg three times daily. Alleviation of symptoms is usually gradual and results may not be observed for 3–4 weeks.
How Supplied: Hydergine tablets (for oral use) 1 mg, packages of 100 and 500. **Hydergine sublingual tablets 1 mg,** containing dihydroergocornine mesylate 0.333 mg, dihydroergocristine mesylate 0.333 mg, and dihydroergocryptine (dihydro-alpha-ergocryptine and dihydro-beta-ergocryptine in the proportion of 2:1) mesylate 0.333 mg, representing a total of 1 mg; packages of 100, 500, and 1000. **Hydergine sublingual tablets 0.5 mg,** containing dihydroergocornine mesylate 0.167 mg, dihydroergocristine mesylate 0.167 mg, and dihydroergocryptine (dihydro-alpha-ergocryptine and dihydro-beta-ergocryptine in the proportion of 2:1) mesylate 0.167 mg, representing a total of 0.5 mg; packages of 100 and 1000.
Before prescribing, see package insert for full product information.

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About the Cover

In keeping with a tradition established by my predecessor, the December cover was designed by the Editor's best friend and closest confidant. The poinsettias pictured (large red, three-bloom, traditional Christmas flower) were gratuitously supplied by the rekowned Paul Ecke Poinsettia Ranch, Encinitas, California. Photography was performed by William Elsner of Jacksonville.

The poinsettia, a native of Mexico and Central America, was brought to the United States in the 1820's by a distinguished South Carolinian diplomat and amateur botanist, Joel Roberts Poinsett. During the early 1900's, the Eckes (considered the grandfathers of poinsettia production) began selling poinsettias as cut flowers and later potted plants. However, the flower did not become a popular Christmas symbol until around 1930.

As exemplified by the poinsettias used for the cover, today's prize specimens are compact with strong leafy canes (stems), large colorful bracts (modified leaves), and a tight flower head. Although the showy bracts are often mistaken for flowers, the true flowers are the yellow and green structures clustered in the center of the bracts.

Daniel B. Nunn, M.D.
Editor



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Professional Liability Legal Update

Wrongful Birth

A jury found that physician/hospital employees had negligently performed a tubal ligation on the plaintiff, with the result that she became pregnant and delivered her sixth child. The plaintiff testified that her child, who was almost two at the time of trial, was a fine and healthly little boy whom she loved very much — just as she did her other children. While she had considered an abortion, she was glad that she had decided against it. The plaintiff was awarded $10,837 for the medical expenses, lost wages, and pain and suffering caused by the undesired pregnancy and the process of childbirth. The appellants challenged neither the liability finding nor the award of these items of damages. Their sole point on appeal concerned the inclusion in the final judgment of $19,500 which was assessed for the past and discounted future reasonable costs of raising the child to age 18, offset by the value of his love and affection, companionship, and the other mother-child relationships.

In reversing the lower court's decision and holding that the cost of raising a previously unwanted but healthy and normal child is not a recoverable element of damages in a so-called "wrongful birth" case, the Third District Court of Appeal aligned itself with a clear majority of courts in other jurisdictions. In the Court's view, the basic soundness of its decision lay in the simple proposition that a parent cannot be said to have been damaged by the birth and rearing of a normal, healthy child. Even the courts in the minority recognized, as the jury was instructed in this case, that the costs of providing for a child must be offset by the benefits supplied by its very existence. The court made it clear, however, that it expressed no opinion as to the issue of whether the costs involved in treating and raising an abnormal or unhealthy child were recoverable.

A dissenting opinion was entered in this case which disagreed with the majority's declaration that, as a matter of public policy, the benefits derived from parenthood exceed any damages which would be incurred in raising an unplanned child whose birth comes about through the negligence of another. The dissent was persuaded that a jury that was instructed, as was the jury in this case, that it could award damages for the cost of raising a child, in the future, offset by the value of his love and affection, companionship and the mother-child relationships, would better express the view and conscious of the community, could measure on a case-by-case basis the enormously varied claims which may arise, and could assess the extent to which the benefits of parenthood should reduce the cost of raising a child.

The dissenting judge stated that it was his belief that the result reached by the majority in the name of humaneness was, unwittingly, inhumane: "I see nothing humane in denying a parent the wherewithal that might save a child from deprivation or, in many cases, abject poverty. I see nothing humane in a rule of law that could enhance the already dire need of parents and existing siblings. I see nothing humane in a decision which effectively immunizes physicians from their negligence and victimizes a mother who sought to relieve herself and her family from the additional burden of another child."

$6.7 Million Verdict Awarded

During the last week of October, a jury in Miami awarded a $6.7 million verdict to a 26-year-old woman who was all but totally paralyzed as a result of severe brain damage suffered during surgery. It was the largest malpractice verdict ever awarded in Florida. The Florida Physicians' Insurance Reciprocal did not insure any of the parties involved in this lawsuit.

The action was brought by the plaintiff and her husband, who are the parents of children ages 4 and 2. The plaintiff was being operated on for cancer of the cervix, which she was assured could most likely be controlled by the surgery. The award was entered against her surgeon, the anesthesiologist, and the hospital.

According to testimony give at trial, since the operation in March, 1979, in which her heart stopped for a period of 15 minutes, plaintiff's body has been curled into a fetal position and she can only move her eyes and head. Indications are that she will require continual nursing care for the rest of her life.

Prepared and submitted by John E. Thrasher, J.D., Vice President and Legal Counsel, and Anthony J. McNicholas III, J.D., Associate Legal Counsel, Professional Insurance Management Co. (PIMCO), Jacksonville, Florida.

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Can you have too much of a good thing?

Too much milk, many pediatricians warn, can fill a child up and consequently, can keep him from eating other foods he needs. Particularly, iron-rich foods.

And, of course, that's a major dietary concern.

But you can also have too little of a good thing. Especially, milk. Milk supplies more essential nutrients per calorie than most other foods.

A child between the ages of six months and six years, for example, can get at least three-fourths of his daily dietary allowance for calcium, riboflavin, vitamins D and B_{12}, phosphorus, and protein from just three glasses of milk. And milk is also a good source of vitamins A and B_6, as well as thiamin and niacin.

That's why the U.S.D.A., acting on the recommendation of the National Research Council—National Academy of Sciences, has established these guidelines for milk consumption:

Children up to 6 years
Two to three 8 oz. glasses per day.

Children 6 to 12 years
Three or more 8 oz. glasses per day.

For a free copy of the Dairy Council Digest issue titled, "Composition and Nutrient Value of Dairy Foods," contact your local Dairy Council or write the National Dairy Council, 6300 North River Road, Rosemont, Illinois 60018.

Per cent of Recommended Daily Allowance contributed by three 8 oz. glasses of fortified milk.

	6 mos.—1 yr.	1 yr.—3 yrs.	3 yrs.—6 yrs.
Calcium	100%	100%	100%
Riboflavin	100	100	100
Vitamin B_{12}	100	100	100
Protein	100	100	80
Phosphorus	100	85	85
Vitamin B_6	76	51	34
Vitamin D	75	75	75
Niacin*	71	63	47
Thiamin	56	40	31
Vitamin A	46	46	37

*maximum niacin equivalents based on:
60 mg tryptophan=1 mg niacin

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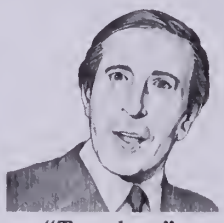
National Dairy Council

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FROM DIETARY COMPLAINTS



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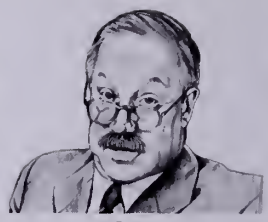
"Tasteless"



"No Variety"



"Hard To Cook"

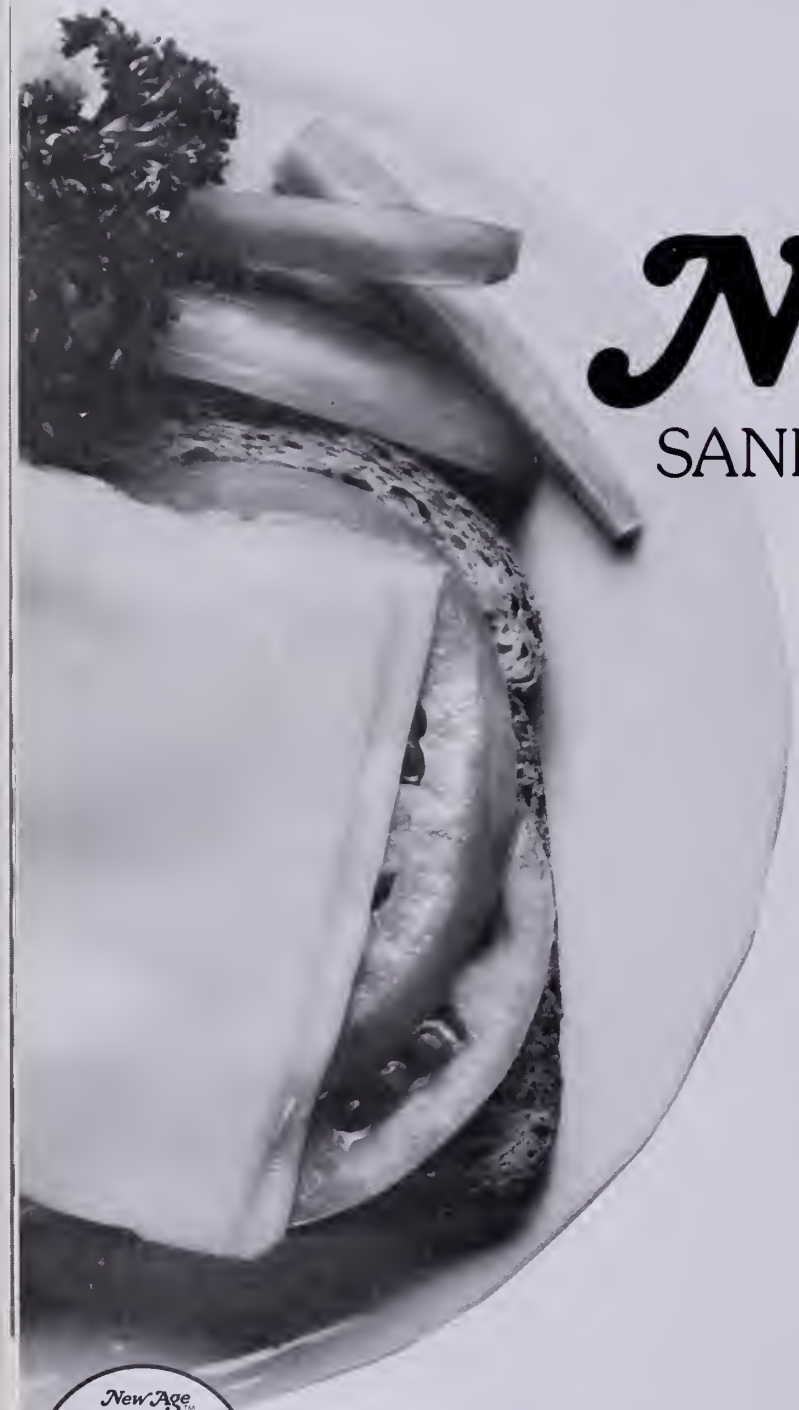


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For Sneezing and Nasal Congestion



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Each prolonged action tablet contains:

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Chlorpheniramine Maleate	8 mg
Hyoscyamine Sulfate	0.19 mg
Atropine Sulfate	0.04 mg
Scopolamine Hydrobromide	0.01 mg

Ru-Tuss Tablets act continuously for 10 to 12 hours.

- Vasoconstrictor, antihistaminic actions
- Rapid and prolonged relief of nasal and sinus congestion
- Convenient b.i.d. dosage

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For Coughing With Nasal and Bronchial Congestion



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Codeine Phosphate	65.8 mg
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Phenylephrine Hydrochloride	30 mg
Phenylpropanolamine Hydrochloride	20 mg
Pheniramine Maleate	20 mg
Pyrilamine Maleate	20 mg
Ammonium Chloride	200 mg
Alcohol	5%

- Vasoconstrictor, antihistaminic, expectorant actions with codeine
- Rapid relief of upper respiratory congestion and cough
- Good tasting

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the Family

SNEEZE

RU-TUSS® TABLETS

DESCRIPTION
Each prolonged action tablet contains:

Phenylephrine Hydrochloride	25 mg
Phenylpropanolamine Hydrochloride	50 mg
Chlorpheniramine Maleate	8 mg
Hyoscyamine Sulfate	0.19 mg
Atropine Sulfate	0.04 mg
Scopolamine Hydrobromide	0.01 mg

Ru-Tuss Tablets act continuously for 10 to 12 hours
Ru-Tuss Tablets are an oral antihistaminic, nasal decongestant and anti-secretory preparation.
INDICATIONS AND USAGE Ru-Tuss Tablets provide relief of the symptoms resulting from irritation of sinus, nasal and upper respiratory tract tissues Phenylephrine and phenylpropanolamine combine to exert a vasoconstrictive and decongestive action while chlorpheniramine maleate decreases the symptoms of watering eyes, post nasal drip and sneezing which may be associated with an allergic-like response The belladonna alkaloids, hyoscyamine, atropine and scopolamine further augment the anti-secretory activity of Ru-Tuss Tablets.
CONTRAINDICATIONS Hypersensitivity to antihistamines or sympathomimetics Ru-Tuss Tablets are contraindicated in children under 12 years of age and in patients with glaucoma, bronchial asthma and women who are pregnant Concomitant use of MAO inhibitors is contraindicated
WARNINGS Ru-Tuss Tablets may cause drowsiness Patients should be warned of the possible additive effects caused by taking antihistamines with alcohol, hypnotics, sedatives or tranquilizers.
PRECAUTIONS Ru-Tuss Tablets contain belladonna alkaloids, and must be administered with care to those patients with glaucoma, or urinary bladder neck obstruction. Caution should be exercised when Ru-Tuss Tablets are given to patients with hypertension, cardiac or peripheral vascular disease or hyperthyroidism Patients should avoid driving a motor vehicle or operating dangerous machinery (See Warnings)
OVERDOSAGE Since the action of sustained release products may continue for as long as 12 hours, treatment of overdoses directed at reversing the effects of the drug and supporting the patient should be maintained for at least that length of time Saline cathartics are useful for hastening evacuation of unreleased medication In children and infants, antihistamine overdosage may produce convulsions and death
ADVERSE REACTIONS Hypersensitivity reactions such as rash, urticaria, leukopenia, agranulocytosis, and thrombocytopenia may occur Other adverse reactions to Ru-Tuss Tablets may be drowsiness, lassitude, giddiness, dryness of the mucous membranes, tightness of the chest, thickening of bronchial secretions, urinary frequency and dysuria, palpitation, tachycardia, hypotension/hypertension, faintness, dizziness, tinnitus, headache, incoordination, visual disturbances, mydriasis, xerostomia, blurred vision, anorexia, nausea, vomiting, diarrhea, constipation, epigastric distress, hyperirritability, nervousness, dizziness and insomnia Large overdoses may cause tachypnea, delirium, fever, stupor, coma and respiratory failure
DOSAGE AND ADMINISTRATION Adults and children over 12 years of age, one tablet morning and evening Not recommended for children under 12 years of age Tablets are to be swallowed whole
HOW SUPPLIED:

Bottles of 100 Tablets	NDC 0524-0058-01
Bottles of 500 Tablets	NDC 0524-0058-05

Federal law prohibits dispensing without prescription

COUGH

RU-TUSS® EXPECTORANT

DESCRIPTION
Each fluid ounce of Ru-Tuss Expectorant contains:

Codeine Phosphate	65.8
(WARNING: MAY BE HABIT FORMING)	
Phenylephrine Hydrochloride	30
Phenylpropanolamine Hydrochloride	20
Pheniramine Maleate	20
Pyrilamine Maleate	20
Ammonium Chloride	200
Alcohol	

Ru-Tuss Expectorant is an oral antitussive, antihistaminic, nasal decongestant c expectorant preparation.
INDICATIONS AND USAGE Ru-Tuss Expectorant is indicated for symptomatic relie upper respiratory congestion associated with pharyngitis, tracheitis, bronchitis, c allergic rhinitis. Also, for the temporary relief of symptoms associated with hay fe allergies, nasal congestion and cough due to the common cold.
CONTRAINDICATIONS Hypersensitivity to antihistamines Concomitant use of an c hypertensive or antidepressant drug containing a monoamine oxidase inhibitc contraindicated
Ru-Tuss Expectorant is contraindicated in patients with glaucoma, bronchial asth and in women who are pregnant.
WARNINGS Ru-Tuss Expectorant contains codeine phosphate, therefore, the pat should be warned of the potential that this drug may be habit forming Ru-Tuss Exp torant may cause drowsiness Patients should be warned of the possible additive ef caused by taking antihistamines with alcohol, hypnotics, sedatives and tranquilize
PRECAUTIONS Patients taking Ru-Tuss Expectorant should avoid driving a motor veh or operating dangerous machinery (See Warnings). Caution should be taken with tients having hypertension, diabetes, hyperthyroidism and cardiovascular disease Caution should also be used in patients with pulmonary, hepatic or renal insufficie
ADVERSE REACTIONS Ru-Tuss Expectorant may cause drowsiness, lassitude, giddin dryness of mucous membranes, tightness of the chest, thickening of bronchial se tions, urinary frequency and dysuria, palpitation, tachycardia, hypotension/hyper sion, faintness, dizziness, tinnitus, headache, incoordination, visual disturbanc mydriasis, xerostomia, blurred vision, anorexia, nausea, vomiting, diarrhea, const tion, epigastric distress, hyperirritability, nervousness and insomnia Overdoses r cause restlessness, excitation, delirium, tremors, euphoria, metabolic acidosis, stu tachycardia and even convulsions
DOSAGE AND ADMINISTRATION Adults: 1 or 2 teaspoonfuls, orally, every 4 hours, nc exceed 10 teaspoonfuls in any 24-hour period
Children 6 to 12 years of age ½ the adult dose, not to exceed 6 teaspoonfuls in 24-hour period. Children 2 to 6 years of age ½ teaspoonful every 4 hours, not to exc 3 teaspoonfuls in any 24-hour period. Children under 2 years of age: Use as directe a physician
HOW SUPPLIED

Pint bottles (16 fl oz)	NDC 0524-101

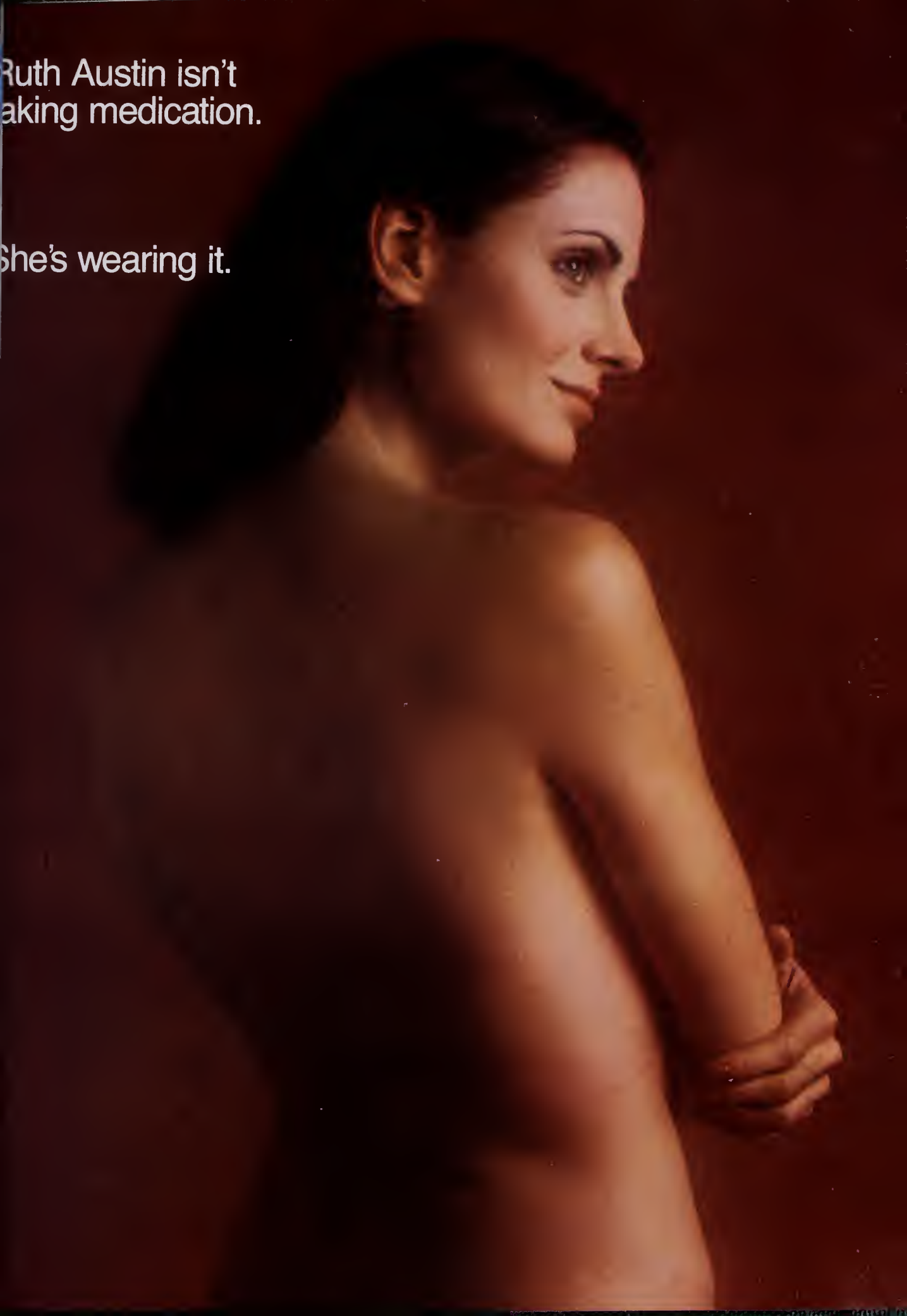
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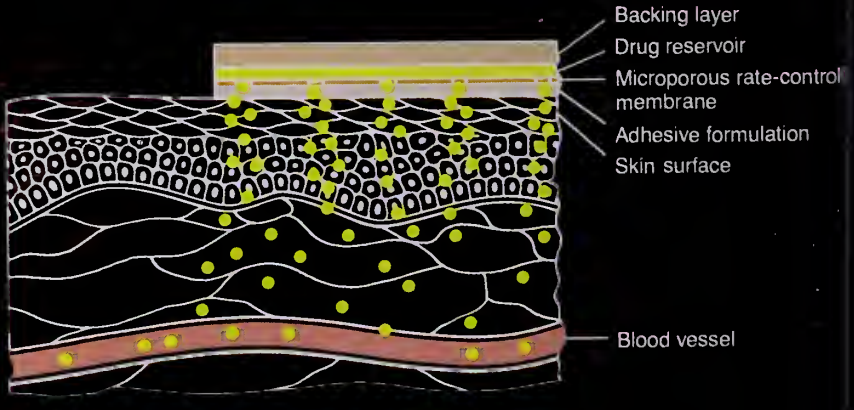

Ruth Austin isn't
aking medication.
She's wearing it.

New from CIBA

Transderm™-V

scopolamine

Transdermal
Therapeutic
System for
motion sickness



Schematic drawing showing cross section of skin surface with Transderm-V in place and delivery of scopolamine to blood vessels.



A small flexible system of membranes worn behind the ear.

Scopolamine: most effective

Scopolamine has long been known as an effective agent for the prevention of motion sickness. But scopolamine in conventional dosage forms causes well-known side effects. Scopolamine in Transderm-V usually does not. The most frequent side effect reported with Transderm-V is dry mouth, occurring in two out of three people. A less frequent side effect is drowsiness, occurring in one out of six people.

Three-day protection

The unique delivery system of Transderm-V is programmed to release just 0.5 mg of scopolamine over a period of three days—enough to give protection against motion sickness. Usually without drowsiness.

Incidence of nausea reduced 75%

How effective is Transderm-V? Studies at sea have shown that Transderm-V reduced the incidence of motion sickness by 75%...oral dimenhydrinate by only 50%.[1]

For best results instruct patients to apply Transderm-V to a hairless spot in the postauricular region several hours—and preferably the night before—a planned trip.

Transderm-V should be used with caution in patients with glaucoma, pyloric obstruction, or urinary bladder neck obstruction.

CIBA

(Please turn page for prescribing information.)

Transderm™-V
scopolamine

Transdermal
Therapeutic System

No highs or lows of plasma concentrations

Because transdermal administration eliminates the relatively high concentrations of drug that follow oral and intramuscular administration, the undesirable pharmacologic effects associated with high drug levels are usually avoided. Yet an effective therapeutic dosage is achieved and maintained—for 72 hours.

Reference

1. Price N, Schmitt LG, Shaw JE, Trobough T, McGuire J. Transdermal delivery of scopolamine for prevention of motion-induced nausea at sea. Data on file, ALZA Corporation, California.

CIBA

Transderm™-V
(scopolamine)

Transdermal Therapeutic System

Programmed delivery *in vivo* of 0.5 mg scopolamine over 3 days

Description Transderm™-V scopolamine system is a circular flat unit designed for continuous release of scopolamine following application to an area of intact skin on the head, behind the ear. Clinical evaluation has demonstrated that the system provides effective antiemetic and antinauseant actions when tested against motion-sickness stimuli in adults.

The Transderm™-V system is a 0.2 mm thick film, with four layers. Proceeding from the visible surface towards the surface attached to the skin, these layers are: 1) a backing layer of aluminized polyester film; 2) a drug reservoir of scopolamine, mineral oil, and polyisobutylene; 3) a microporous polypropylene membrane that controls the rate of delivery of scopolamine from the system to the skin surface; and 4) an adhesive formulation of mineral oil, polyisobutylene, and scopolamine. Prior to use, a protective peel strip of siliconized polyester which covers layer 4 is removed.

The mineral oil (12.4 mg) and polyisobutylene (11.4 mg) inactive components are not released from the system.

Release Rate Concept: Transderm™-V system, 2.5 cm^2 in area, contains 1.5 mg scopolamine. The system is programmed to deliver 0.5 mg scopolamine, at an approximately constant rate to the systemic circulation, over the 3-day lifetime of the system. An initial priming dose of scopolamine released from the adhesive layer of the system, saturates the skin binding sites for scopolamine and rapidly brings the plasma concentration to the required steady state level. The continuous controlled release of scopolamine, that follows from the drug reservoir through the rate controlling membrane, then maintains the plasma level constant.

Clinical Pharmacology The formulation of the Transderm™-V system contains as its sole active agent the drug scopolamine, a belladonna alkaloid with well-known pharmacological properties. The drug has a long history of oral and parenteral use for central anticholinergic activity, including prophylaxis of motion sickness. This formulation provides for a gradual release of scopolamine from an adhesive matrix of mineral oil and polyisobutylene applied to the postauricular skin.

Clinical Results: The Transderm™-V system provides antiemetic protection within several hours following application of the system behind the ear. With the 195 adult subjects of different racial origins who participated in clinical efficacy studies at sea or in a controlled motion environment, there was a 75% reduction in the incidence of motion-induced nausea and vomiting. The Transderm™-V system provided significantly greater protection than that obtained with oral dimenhydrinate.

Indications and Usage The Transderm™-V system is indicated for prevention of nausea and vomiting associated with motion sickness in adults. The system should be applied only to skin in the postauricular area.

Contraindications Transderm™-V system should not be used in patients with known hypersensitivity to scopolamine or any of the components of the adhesive matrix making up the therapeutic system.

Warnings Since drowsiness, disorientation and confusion may occur with the use of scopolamine, patients should be warned of the possibility and cautioned against engaging in activities that require mental alertness, such as driving a motor vehicle or operating dangerous machinery.

Potentially alarming idiosyncratic reactions may occur with ordinary therapeutic doses of scopolamine.

Usage in Children: Children are particularly susceptible to the side effects of belladonna alkaloids. Transderm™-V system should not be used in children because it is not known whether this system will release an amount of scopolamine that could produce serious adverse effects in children.

Precautions Scopolamine should be used with caution in patients with glaucoma, pyloric obstruction, or urinary bladder neck obstruction. Caution should be exercised when administering an antiemetic or antimuscarinic drug to patients suspected of having intestinal obstruction.

Pregnancy: Reproductive studies have been performed in rats and rabbits and have revealed no evidence of impaired fertility or harm to the fetus due to scopolamine administered, with plasma levels in excess of those attained by use of the Transderm™-V system in humans. However, the Transderm™-V system should be used in pregnant women with motion sickness only when clearly needed.

Nursing Mothers: It is not known whether scopolamine is excreted in human milk. As a general rule, nursing should not be undertaken while a patient is on a drug since many drugs are excreted in human milk.

Adverse Reactions The most frequent adverse reaction to the Transderm™-V system is dryness of the mouth. This occurs in about two-thirds of the people. A less frequent adverse reaction is drowsiness, which occurs in less than one-sixth of the people. Transient impairment of eye accommodation is also observed. The following adverse reactions have also been reported on infrequent occasions during use of the Transderm™-V system: disorientation, memory disturbances, restlessness, giddiness, hallucinations and confusion.

Overdosage Overdosage with scopolamine may cause disorientation, memory disturbances, restlessness, giddiness, hallucinations or confusion. Should these symptoms occur, the Transderm™-V system should be immediately removed. Appropriate parasympathomimetic therapy should be initiated if these symptoms are severe.

Dosage and Administration *Adults: Initiation of Therapy:* One Transderm™-V system, programmed to deliver 0.5 mg scopolamine over three days, should be applied to the postauricular skin several hours before the antiemetic effect is required.

Handling: The hands should be washed and dried thoroughly before applying the system on dry skin behind the ear. Upon removal of the system it should be discarded and the hands and application site washed thoroughly to prevent any traces of scopolamine from coming into direct contact with the eyes. A patient brochure is available.

Continuation of Therapy: Should a system become displaced, it should be removed and replaced with a second system on a fresh skin site in the postauricular area. If therapy is required for longer than 72 hours, the first system should be removed and a second system placed on a fresh skin site in the postauricular area.

Children: Children are particularly susceptible to the side effects of belladonna alkaloids. Transderm™-V system should not be used in children because it is not known whether this system will release an amount of scopolamine that could produce serious adverse effects in children.

How Supplied Transderm™-V systems are available in 2-unit blister packs.

Storage and Handling The system should be stored at room temperature.

Caution Federal law prohibits dispensing without prescription.

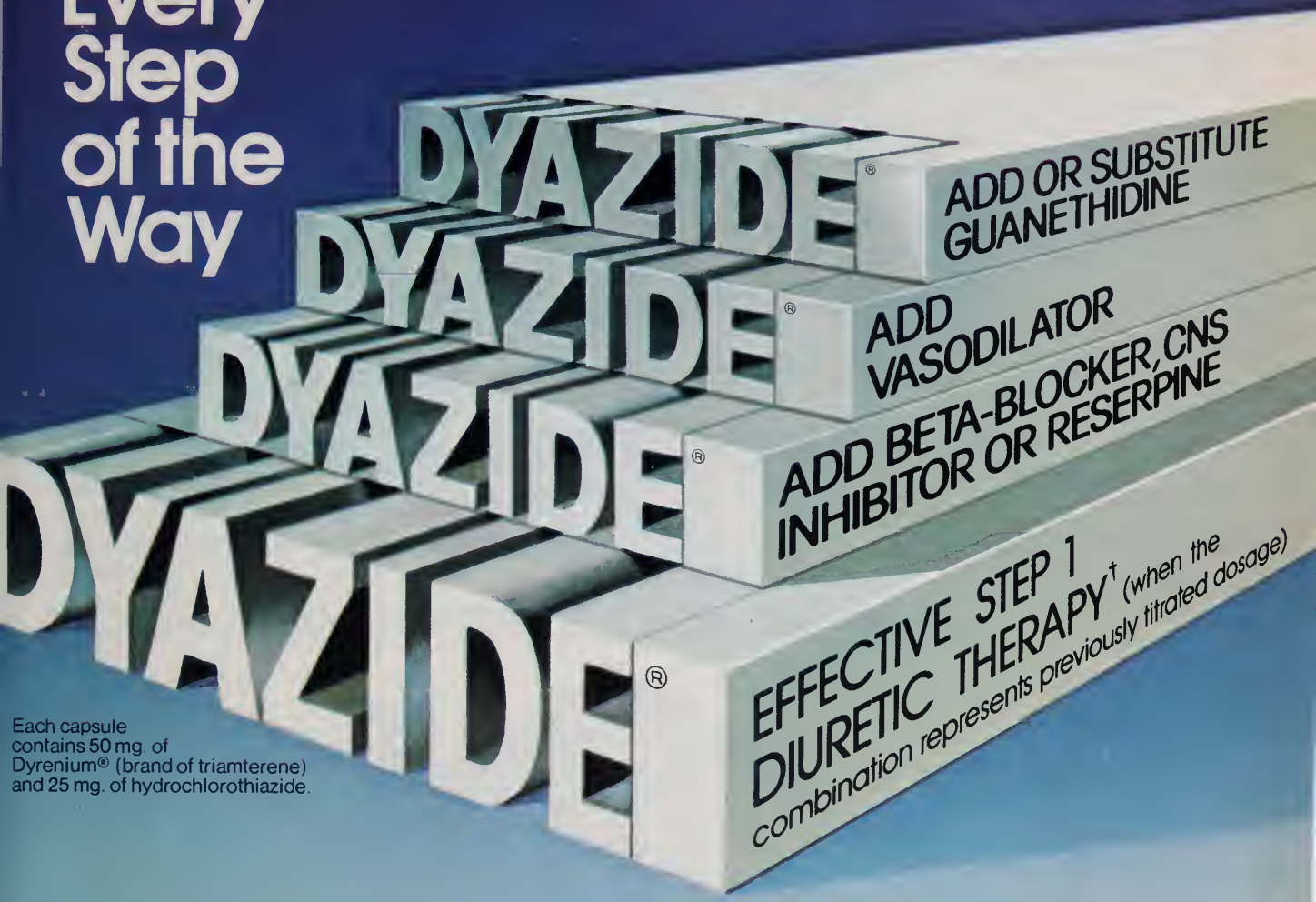
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In Hypertension*...When You Need to Conserve K^+

Every Step of the Way



Each capsule contains 50 mg. of Dyrenium® (brand of triamterene) and 25 mg. of hydrochlorothiazide.

†Step 1 usually consists of an initial phase (a diuretic alone), a titration phase (dosage adjustment and/or addition of a K^+ supplement or K^+-sparing agent), and a maintenance phase (a diuretic alone or in combination with a K^+ supplement or K^+-sparing agent).

Serum K^+ and BUN should be checked periodically (see Warnings).

Before prescribing, see complete prescribing information in SK&F Co. literature or *PDR*. A brief summary follows:

* **WARNING**
This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effect may be enhanced in postsympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia, although uncommon, has been reported. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function.

Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components.

Supplied: Bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.

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works well in your office...

NEOSPORIN® Ointment

(polymyxin B-bacitracin-neomycin)

Each gram contains: Aerosporin® (Polymyxin B Sulfate) 5,000 units, bacitracin zinc 400 units, neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

works just as well in their homes.

- It's effective therapy for abrasions, lacerations, open wounds, primary pyodermas, secondarily infected dermatoses.
- It provides broad-spectrum overlapping antibacterial effectiveness against common susceptible pathogens, including staph and strep.



- It helps prevent topical infections, and treats those that have already started.
- It contains three antibiotics that are rarely used systemically.
- It is convenient to recommend without a prescription.

NEOSPORIN® Ointment—for the office, for the home.

(polymyxin B-bacitracin-neomycin)

Effective • Economical • Convenient • Recommendable

Each gram contains: Aerosporin® (Polymyxin B Sulfate) 5,000 units, bacitracin zinc 400 units, neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of non-susceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.

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THE JOURNAL
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Pneumonectomy in Nonneoplastic Disease Its Role in Current Therapy

Richard J. Thurer, M.D.

Abstract: A recent experience with pneumonectomy performed for benign disease is discussed. The pathologic entities for which this operation is indicated and the studies required for adequate preoperative evaluation are reviewed. Although indications for pneumonectomy in benign disease are limited, it is occasionally required, particularly for the complications of tuberculous infection. Other problems may warrant the procedure. It is, therefore, important that appropriate operative techniques and methods of preoperative evaluation and case selection remain in the armamentarium of thoracic surgeons.

Pneumonectomy is employed almost exclusively in the management of primary malignant lesions of the lung. We have, however, encountered patients in whom total lung resection was required for nonneoplastic disease.

The case records were reviewed of 10 consecutive patients who required pneumonectomy for benign disease. They were seen between 1970 and 1976. The patients represent approximately 10% of all patients requiring pneumonectomy during this period. All other patients were operated upon for neoplastic disease, most for bronchogenic carcinoma. There were no instances in which a planned lobectomy for nonneoplastic disease had to be converted to a penumonectomy because of intraoperative technical difficulties.

The diagnoses in this group of patients are listed in Table 1. Six had pulmonary tuberculosis, two were resected under emergency circumstances for traumatic injuries, one underwent operation for a congenital anomaly, and the other had bronchiectasis. The indications for operation in the tuberculous patients were recurrent hemoptysis and/or recurrent nontuberculous infection. All patients resected for tuberculosis were chronic alcoholics.

Table 1. — Pneumonectomy in Nonneoplastic Disease.

Diagnosis		
Tuberculosis	6	
Trauma	2	
Congenital anomaly	1	
Bronchiectasis	1	
Operative Mortality by Diagnosis		
Tuberculosis	16%	(1/6)
Trauma	100%	(2/2)
Congenital anomaly	0%	(0/1)
Bronchiectasis	0%	(0/1)

The average age of the 10 patients was 35, the youngest being 11 years of age. All were male. One patient operated upon electively died; both those with

The Author

RICHARD J. THURER, M.D.

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Fig. 1. — Bronchiectasis, empyema and bronchopleura fistula. Bronchogram indicating severe generalized saccular bronchiectasis of the left lung with bronchopleural communication.



Fig. 2. — Pulmonary tuberculosis, late sequelae. Chest roentgenogram, frontal projection, indicating mediastinal shift to the right, opacification of the right midlung field and calcified pleura.

trauma died. In the surviving patients there have been no late deaths and no late empyemas.

Of the traumatic cases the first patient sustained a gunshot wound to the lung, aspirated blood into the opposite lung, required bilateral thoracotomy for resection and resuscitation from cardiac arrest, and died 24 hours after operation of respiratory failure. The second patient was an 11-year-old boy who sustained a massive electrical burn which resulted in necrosis of the right arm, leg, chest wall and lung. The lung was resected in two stages; a modified thoracoplasty was performed but the patient died of sepsis three weeks following injury.

Figures illustrate the specific types of pathology encountered (Figs. 1-6).

Discussion

Patients considered for extrapleural resection typically have severely impaired pulmonary function as measured by conventional studies. A representative patient may have lung volumes reduced by 50% with some degree of hypoxia. Differential perfusion lung scanning often indicates essentially no pulmonary artery blood flow to the involved lung. If a small amount of flow is preserved, this usually contributes to intrapulmonary shunting with resultant hypoxemia. In such situations resection can clearly result in improvement in pulmonary function.

Prior to the era of modern antituberculous chemotherapy an extensive experience developed with pulmonary resection, including pneumonectomy, for tuberculosis. Since surgical intervention in pulmonary tuberculosis has decreased, pulmonary resection, especially pneumonectomy, is now primarily employed in the treatment of neoplastic disease. As pointed out, however, pneumonectomy is occasionally required for benign conditions other than tuberculosis.

In situations other than trauma the indications for total pneumonectomy are similar. Recurrent hemoptysis and recurrent episodes of sepsis resulting in systemic symptoms and generalized debility are usual indications. When a nonfunctioning or "parasitic" lung can be demonstrated and contralateral lung function is ade-



Fig. 3. — Bronchiectasis. Chest roentgenogram, frontal projection, indicating mediastinal shift to the left, cystic changes and fibrosis of left lung and left fibrothorax.



Fig. 5. — Congenital anomaly, variant of cystic adenomatoid malformation. Chest roentgenogram, frontal projection, demonstrating mediastinal shift to the left, fibrosis and bullous disease and pleural thickening.



Fig. 4. — Bronchiectasis. Bronchograms indicating generalized bronchiectasis of left lung.

quate, pneumonectomy is advised. These considerations apply to patients with tuberculous as well as nontuberculous infections and some congenital lesions.

Indications for resection in tuberculosis which evolved in the prechemotherapeutic era are not now applicable. At that time indications included thoracoplasty failure, anticipated thoracoplasty failure and the inability to achieve sputum conversion and/or cavity closure. Emergency resections were also necessary for uncontrolled hemorrhage and cavity rupture.[1]

In the past, preoperative investigations included an assessment of contralateral disease. Some disease was present in half of all patients; however, extensive cavitation was believed to be a contraindication to resection. Physiological assessment of lung function was also believed to be of major importance. This was investigated extensively and the role of pulmonary insufficiency in mortality and invalidism following operation elucidated. It was found that death or some degree of pulmonary insufficiency occurred in 40% of patients undergoing pneumonectomy.[2] Functional studies were employed to determine the effects of various surgical procedures, such as thoracoplasty, after pneumonectomy.[3] Definite contraindications to resectional surgery were believed to



Fig. 6a. — Congenital anomaly, variant of cystic adenomatoid malformation. Pulmonary angiogram, left anterior oblique projection, indicating lack of filling of left pulmonary artery.

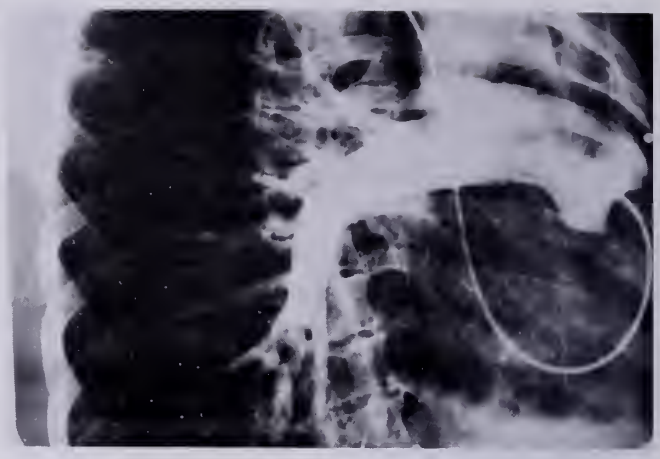


Fig. 6b. — Congenital anomaly, variant of cystic adenomatoid malformation. Pulmonary angiogram, right anterior oblique projection, indicating filling of proximal 1 cm of left pulmonary artery.

be respiratory inadequacy of the contralateral lung, uncontrolled contralateral disease, tracheal tuberculosis, debilitating extrapulmonary disease and extensive amyloidosis.

The crucial question is always the adequacy of contralateral function. Current methods of evaluation allow accurate prediction of postoperative lung function after pneumonectomy.[4-7]

Assessment of unilateral lung function initially involved bronchial intubation with a double lumen Carlen's tube and also right heart catheterization with occlusion of a pulmonary artery. Recent methods employing perfusion lung scans allow assessment accurately and noninvasively.

In the patients reviewed a number of techniques were used in evaluation. The guidelines of Olsen and Block[7] were generally followed. Perfusion lung scans were made with differential counting anteriorly and posteriorly over each hemithorax. A predicted postoperative FEV_1 of over 800 ml, arrived at by multiplying the fraction of perfusion or ventilation to the remaining lung by the preoperative FEV_1, was taken as the limiting value in terms of operability. The perfusion scan alone is felt to be satisfactory in making this determination.[7] Occasionally angiography was used, usually only in conjunction with cardiac catheterization and balloon pulmonary artery occlusion. An interesting finding in a number of patients was the lack of pulmonary artery filling by angiography despite the presence of a patent proximal artery found at operation.

Surgery is now rarely employed in the treatment of bronchiectasis. As in the case reviewed, operation is occasionally required when recurrent infection cannot be controlled and the disease is localized. Lobectomy is usually adequate, although pneumonectomy is sometimes necessary. The extent of disease must be carefully mapped bilaterally by bronchography. Using scanning techniques, lack of perfusion, and therfore function must be demonstrated on the involved side as well as adequate function on the contralateral side. There can be no compromise with adequate preoperative functional assessment.

Congenital lesions are occasionally not recognized until adult life. Evaluation is similar to that outlined, but should also include angiography to uncover any unusual vascular connections which might allow precise classification of the anomaly and also greater safety at operation.[8] Here, also, total involvement with virtually no detectable lung function on the involved side should be insisted upon. If significant function is present, a lesser resection should be done.

Pneumonectomy in childhood has been performed for a variety of indications. Late studies have generally shown that these children do well if not left with residual disease. The size of the remaining lung increases along with total lung capacity, sometimes to volumes greater than normal for individuals with two lungs.[9]

Animal studies have indicated that late pulmonary function is better when pneumonectomy is done very early in life. In cats, true hyperplasia and alveolar distension occur after pneumonectomy at an early age.[9]

Traumatized patients requiring pneumonectomy often have sustained potentially lethal injuries. In this

series no patient undergoing pneumonectomy for trauma survived. Pulmonary resection of any magnitude is rarely required for trauma. On the other hand, resection may be required for severe injuries involving major vessels of the hilum. The usual indication for pulmonary resection acutely is a severely damaged lung with a connection between a bronchus and pulmonary vessel which results in inability to maintain a clear airway and adequate ventilation. When such injuries are central or involve a major portion of a lung, aspiration into the opposite lung is often so extensive as to make adequate ventilation impossible.

Surgical management of patients subjected to pneumonectomy must be meticulous. Accurate diagnosis and functional assessment is critical. In patients with infection, adequate material for culture must be obtained; this is true in both tuberculous and nontuberculous cases. With recurrent pulmonary infection, anaerobes must be assumed to be present. Adequate antimicrobial therapy is important to a successful outcome. Usually a new antibiotic program employing drugs known to be effective by sensitivity studies is begun preoperatively and continued for five to seven days postoperatively. Antituberculous therapy when indicated is continued so as to complete a therapeutic course.

Whenever possible, every effort should be made to improve the patient's nutritional status prior to operation. Dietary supplements administered by mouth or intravenous hyperalimentation may be necessary and beneficial in achieving an anabolic state preoperatively.

Although the prone position has been used extensively in pulmonary resection, in this series lateral thoracotomy was employed with isolation of each lung achieved by a Carlen's type tube or bronchial blocker. No difficulties were encountered with this method.

Safe conduct of the operative procedure requires extrapleural mobilization of the lung prior to attempting division of hilar structures. The mediastinal structures and hilum are usually free of the intense inflamatory reaction encountered laterally. An effort at early control of the bronchus may be made, particularly on the right side, but any such attempt at hilar dissection prior to mobilization and encirclement of the hilum must be made with great care. Bronchial closure is achieved using stapling instruments. Rarely is tissue available for satisfactory covering of the staple line. Hilar vessels are divided after proximal control with vascular clamps and the ends oversewn with fine vascular suture. In most patients balanced drainage of the pleural space is employed using two tubes[10] (Fig. 7). This allows an empty pleural space to be maintained and permits accurate recording of blood loss into the space. The system is used for three to five days. Antibiotics are then instilled into the pleural space and the tubes removed. No empyemas have been recognized in the patients treated by this method.

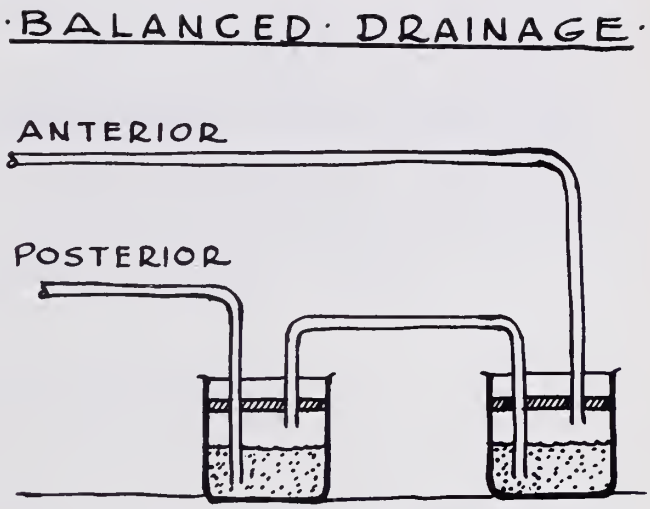


Fig. 7. — Balanced drainage system illustrating the connections of the anterior or apical tube and the posterior or basilar tube. Drainage of fluid or air from either tube results in displacement into the chest of an equivalent volume of air thus maintaining the mediastinum in a stable position and tending to keep the pleural space free of fluid. A trap bottle may be inserted between patient and system pictured to allow for fluid drainage without altering pressure relationships.

In evaluating patients every effort should be made to determine if any potentially functioning lung tissue can be conserved. In this series of patients it was determined that essentially no significant functional lung was present unilaterally and pneumonectomy was therefore done.

Conclusions

This series of cases is presented to indicate that pneumonectomy continues to be employed in the treatment of nonneoplastic disease. Lessons learned during the period when surgical therapy was often used in the treatment of tuberculosis must not be forgotten since they occasionally have application today. These lessons in combination with modern chemotherapeutic agents and postoperative management should result in safe and successful surgical management.

In addition, patients with diverse lesions ranging from congenital anomalies to trauma may require total pneumonectomy. Whenever possible complete preoperative evaluation is necessary to properly select those patients who will benefit from resection of this magnitude. magnitude.

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Long Term Oral Vasodilator Therapy in Severe Right Ventricular Failure Due to Right Ventricular Infarction

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Abstract: A patient with acute myocardial infarction developed evidence of severe right ventricular dysfunction. Based on hemodynamics, the diagnosis of right ventricular myocardial infarction was made. The patient was treated with intravenous nitroprusside and volume expansion with marked improvement in cardiac output. For long term nonparenteral therapy, trials with oral vasodilators were given. Oral prazosin reduced the venous return (right atrial pressure) and resulted in only modest increase in cardiac output. Oral hydralazine reduced systemic vascular resistance without affecting the venous return and maintained cardiac output at optimum levels comparable to administrationof intravenous nitroprusside and volume expansion. Thus, selective afterload reduction may be beneficial in patients with severe right ventricular dysfunction related to right ventricular infarction.

Acute myocardial infarction is usually presumed to involve left ventricle. Recent reports suggest that right ventricle may also be involved in 2 to 34% of patients.[1-4] The recognition of right ventricular infarction is important from the view point of management. Cohn, et al[1,5] first suggested judicious use of load reduction therapy with nitroprusside in association with volume expansion to improve the hemodynamic function in patients with right ventricular dysfunction related to predominant right ventricular infarction. However, intravenous nitroprusside and volume expansion are beneficial only for the duration of infusion. For long term management of patients with right ventricular dysfunction, use of orally administered agents would appear practical.

In this report, we describe a patient with severe right ventricular dysfunction treated with several oral vasodilators in an attempt to determine the most beneficial pharmacologic agent.

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Case Report

A 57 year old man was hospitalized with first episode of severe chest pain, nausea and vomiting. Past history consisted of retinal artery emboli and aorto-femoral bypass for occlusive vascular disease. Examination at admission revealed normal vital signs and stable cardiac status. Electrocardiogram was consistent with transmural inferior wall myocardial infarction. On the following day, the patient became hypotensive (blood pressure 76/60 mmHg) and tachycardic (heart rate 140/minute). However, he had only minimal orthopnea. The heart sounds were faint. Jugular venous pressure was markedly elevated. The urinary output progressively declined. Swan Ganz catheterization revealed inappropriately high right atrial pressure (19mm Hg), mildly elevated pulmonary capillary wedge pressure (18mm Hg) and reduced cardiac output (2.5 L/min) (Table). Diagnoses of right ventricular infarction and/or pericardial effusion were considered, but the latter was ruled out by echocardiography.

The patient was treated with saline (1,400 ml every 8 hours) and nitroprusside infusion. Over the next 3 days on this therapy, the heart rate and arterial pressure stabilized and cardiac output increased to 4.5 L/min. In the interim, the patient developed Mobitz type II second degree atrio-ventricular block requiring a pacemaker insertion. Any attempts to decrease nitroprusside and fluid infusion resulted in marked decline in cardiac output. In an attempt to determine appropriate oral agent, the patient was given oral prazosin (4 mg) every 6 hours for 2 days while nitroprusside was discontinued. Oral intake of fluids was encouraged. With prazosin therapy, pulmonary artery, pulmonary capillary wedge and right atrial pressures slightly decreased as the cardiac output also declined from 4.5 to 3.5 L/min (Table). Subjectively, the patient reported feeling better with intravenous nitroprusside and fluid administration compared to oral prazosin. Parzosin was then stopped and hydralazine 75 mg substituted orally every 8 hours starting

on the 9th hospital day. With hydralazine, pulmonary artery, pulmonary capillary wedge and right atrial pressures increased slightly, but cardiac output was markedly higher (5.5 L/min) compared to therapy with either intravenous nitroprusside and volume expanders or oral prazosin. The vascular resistance in the systemic and pulmonary vascular beds also declined. Subjectively the patient felt considerably improved with marked diminution in fatigue. The jugular venous pressure was still elevated, but urinary output had increased.

In order to determine whether the improvement was related to hydralazine therapy or spontaneous improvement in cardiac function, hydralazine was withheld on the 12th hospital day for 24 hours. The blood pressure and cardiac output declined to the control state (3rd hospital day). Hydralazine was then restarted and patient was discharged on the 23rd hospital day.

The patient has now been followed for six months. He still has elevated jugular venous pressure and pulsatile liver, but only minimal orthopnea and shortness of breath. Cardiac catheterization done at six months following myocardial infarction showed right ventricular dysfunction (right atrial pressure — 18 mm Hg, right ventricular pressure 35/18 mm Hg) and slight left ventricular dysfunction (left ventricular end-diastolic pressure — 14 mm Hg). Cardiac output was preserved at 4.8 L/min. The entire right ventricular inferior and free walls were observed to be akinetic on right ventriculogram, and a left ventriculogram showed segmental anteroseptal hypokinesia. The right coronary artery was completely occluded at its origin. Significant proximal lesions in the left circumflex and anterior descending coronary arteries were also observed.

Discussion

The clinical and hemodynamic profiles of right ventricular myocardial infarction have been described in several recent reports.[1,6,7] A shock like state following myocardial infarction, inappropriate increase in right atrial pressure, usually an infero-posterior myocardial infarction pattern and atrio-ventricular blocks suggest involvement of the right ventricle. Since the principles of therapy of circulatory collapse accompanying predominant right ventricular infarction are different from those in isolated left ventricular infarction, the differentiation is of considerable importance.

Several investigators[1,5-7] have reported the beneficial effects of intravenous nitroprusside and volume expanders in patients with right ventricular dysfunction accompanying acute myocardial infarction. Reduced cardiac output and circulatory collapse are manifestations of impairment of the right ventricular function accompanying extensive right ventricular myocardial damage.[1,5] It has been reasoned that nitroprusside infusion would decrease the resistance in the systemic vascular bed and lead to improved emptying of left ventricle. The improved pumping of left ventricle may facilitate passage of blood passively through the right ventricle and pulmonary vascular bed, if central blood volume is also simultaneously increased. Although this mode of therapy has been useful in improving hemodynamic functions in certain patients, the overall prognosis of patients with severe right ventricular dysfunction either alone or in association with left ventricular failure remains guarded.[1,5-7] Therapy with intravenous nitroprusside and volume expanders in this patient was indeed beneficial as evidenced by the increase in cardiac output and mean arterial pressure, and a marked decrease in heart rate. For long term management of this patient with predominant right ventricular infarction and circulatory collapse, use of an oral vasodilator appeared necessary.

Prazosin administration in this patient resulted in a decrease in vascular resistance in the systemic and pulmonary vascular beds. Although, cardiac output increased compared to the control state, it was somewhat lower than that during intravenous nitroprusside and volume expansion therapy. The patient's symptoms of fatigue became pronounced. It can be hypothesized that equivalent dilation of arterial and venous beds by prazosin[8,9] resulted in reduction in venous return (decrease in right atrial pressure) and systemic vascular resistance. Administration of prazosin alone in combined right and left ventricular dysfunction would seem to improve left ventricular performance by decreasing systemic vascular resistance, but a decline in venous return to the right ventricle might not be beneficial. The venodilatory effect would thus negate the salutary effects derived from improved left ventricular emptying in patients with predominant right ventricular dysfunction unless the central blood volume is simultaneously increased.

Hydralazine therapy resulted in a marked decline in systemic vascular resistance and rise in cardiac output Subjectively, the patient was considerably improved. The improvement with hydralazine was related to the therapy, rather than spontaneous improvement in right ventricular function since withdrawal of hydralazine reproduced the clinical and hemodynamic pattern of right ventricular dysfunction. Hydralazine is a relatively

Table 1. — Hemodynamic Effects of Intravenous Nitroprusside and Volume Expansion, Oral Prazosin and Oral Hydralazine.

	Control	NP and Fluids	Prazosin	Hydralazine
HR (b/min)	140	100	90	90
MAP (mmHg)	65	74	70	70
MPAP (mmHg)	25	27	23	27
PCWP (mmHg)	18	20	15	15
RAP (mmHg)	19	22	16	20
CO (L/min)	2.5	4.5	3.5	5.5
SVR (dynes sec-cm ^{5})	1,472	924	1,234	727
PVR (dynes sec-cm ^{5})	224	124	183	160

Abbreviations: NP — nitroprusside, HR — heart rate, MAP — mean arterial pressure, MPAP — mean pulmonary arterial pressure, PCWP — pulmonary capillary wedge pressure, RAP — right atrial pressure, CO — cardiac output, SVR — systemic vascular resistance, PVR — pulmonary vascular resistance.

selective dilator of the arterial bed with only minimal effects on the venous capacitance vessels.[10] In clinical studies in congestive heart failure patients, hydralazine markedly improves cardiac output with only minimal effects on heart rate, systemic arterial, pulmonary arterial and right atrial pressures.[10 12] The greatly improved status of our patient with hydralazine may thus be related to marked afterload reducing properties of hydralazine with no impairment in the venous return. The enhanced pumping action of the left ventricle probably facilitated passive return of venous flow through the right ventricle and pulmonary vascular bed. In addition, direct inotropic actions of hydralazine may have contributed to increase in cardiac output.[13]

This report suggests that severe right ventricular dysfunction appearing in the setting of acute myocardial infarction is indicative of predominant right ventricular infarction. The treatment of circulatory collapse associated with right ventricular infarction is different from that of left ventricular infarction, and requires an understanding of pathophysiologic and pharmacologic concepts.

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Drug Abuse Treatment in Correctional Institutions in Florida: Facilities and Techniques

Edward B. Jaffe, M.D.

Editor's Note: The Board of Governors of the Florida Medical Association recommended on April 30, 1980, that a study commission on prison drug abuse treatment programs be appointed by the Florida Department of Corrections. The Department agreed to consider the request upon review of the report on the subject prepared under the auspices of the FMA Council on Medical Services. The following article is a summarization of the study conducted by Edward B. Jaffe, M.D., a member of the FMA Committee on Drug Abuse. The article has concurrently been submitted to the Department of Corrections for review.

Since its inception the Florida Medical Association's Committee on Drug Abuse has been concerned with the proper delivery of treatment and rehabilitation of past abusers. Recent correspondence with the National Prison Project based in Washington, D.C., engendered interest in this field as it related to the correctional institutions in Florida. This interest was heightened by a study of statistics from the Department of Corrections which indicated that 42% of the inmates in Florida's prison system admitted to abusing drugs and that 12% were there for drug related offenses. Adding alcohol abusers increased the number to 70% of the prison population who admitted to substance abuse. These figures indicated the value of a preliminary study relative to the problem of rehabilitation of the drug abuser in the state prison system.

The Florida Medical Association's Committee on Drug Abuse recommended that this study be instituted and the Council on Medical Services gave its approval. There was no grant written and no funds available or authorized. I undertook the project with official cognizance but without state funding.

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Dr. Jaffe is a member of the Florida Medical Association's Committee on Drug Abuse.

Method of Study and Sources

Initially, background information was obtained through correspondence with the Department of Corrections and many of the correctional institutions. A visit was made to the Department of Corrections and interviews there provided valuable information relative to drug abuse therapy in the prison system. Of the 22 major installations in Florida, six which operated drug abuse programs were selected for this study and site visits were made to those institutions. Interviews with the directors, staff and, in some instances, discussions with inmates produced the information on which this study is based. Finally some of the community-based drug abuse treatment centers were visited and information from these sources was coordinated into this report.

Types of Programs

The study revealed that there were three methods of approach to the organization of drug abuse programs in Florida's prison system. One type of program consists of counseling services provided in the institution by the Department of Corrections. A second type somewhat unique to Florida is a therapeutic community which operates within the confines of the prison. The third type is an experimental program which utilizes community-based therapeutic centers and permits certain prisoners to live at these centers while undergoing therapy. The prisoners are still considered inmates of the correctional institution and "serving their time."

Counseling Services

There are individual counseling and group sessions. The training of the counselors ran the gamut from career personnel who have been guards (correctional officers) and classification officers through clergy to clinical psychologists. Some groups are counseled by outside

sources such as Alcoholics Anonymous, churches and counselors from therapeutic communities who are sent to help the prison system programs.

Therapeutic Community Within Prison Complex

There are several correctional institutions which have therapeutic communities within the confines of the prison. Lantana Correctional Institution has developed a plan which is unique. One wing of the A. G. Holly Tuberculosis Hospital has been converted into a medium security institution and is used as a rehabilitation center for drug abusers. Inmates are housed in the original hospital rooms. The doors are unbarred in each room while the institution has bars and correctional officers circumferentially. All the inmates participate in the therapeutic program for a period of time generally six months to one year. This program is operated primarily by professionally trained counselors.

Jones Cottage at Florida Correctional Institution at Lowell maintains completely separate housing although inmates use the dining areas and some of the other main prison facilities. The cottage has a locked gate and a surrounding fence, but allows much more interior freedom than is permitted in the remainder of the institution. This program is also operated by professionally trained counselors.

Karma House at Sumter Correctional Institution at Bushnell and New Life Organization at DeSoto Correctional Institution at Arcadia each have one dormitory in which all inmates participate in therapy. Under the supervision of a drug abuse counselor, the inmates themselves assume progressively more responsibility for supervising group sessions and helping newer inmates adjust to the therapeutic community. These three concepts represent the different degrees of isolation of the therapeutic community within the prison itself.

Community-Based Therapeutic Communities

The value of therapeutic communities as a means of drug abuse rehabilitation is well established. The success rate of such programs, while by no means universal, is far higher than other forms of treatment and is provided at a much more reasonable cost. Most programs plan a residence of six to 18 months and are directed by a combination of professional personnel and ex-abusers. For the past eight years, the Department of Corrections has had a program wherein prisoners who fit the strictly defined criteria were placed into such programs and remained for the usual six to 18 months undergoing classical phases of rehabilitation. These inmates receive credit for time served while in the therapeutic community. This program has been included in the Department of Corrections allocation by the legislature.

Comments

There appear to be two major questions in reference to drug abuse treatment in the prison system. First, are these programs having a positive effect? and, second, if so which program should be utilized? Referring again to Department of Correction statistics, if 70% of inmates in the correction facilities are drug abusers, and if over 12% of the 20,000 plus inmates are in prison for drug-related offenses, there are indeed a large enough number of people involved to warrant the use of deterrents to recidivism. Twenty or more years ago it was accepted that there was a 98% long-term failure in the treatment of narcotic addiction. The present day approach to counseling and other concepts of treatment has changed that outlook. It is currently understood that the problems to be overcome are those concerned with the development of coping mechanisms, decision making, and the mature handling of interpersonal and interfamilial relationships. The institution of long-range counseling and peer-group psychotherapy (rap sessions, encounter groups, marathons) have improved statistics almost twentyfold, from 2% success to 40% success overall and better with selected clientel. Continuation and expansion of drug abuse treatment in the prison system is definitely indicated.

In evaluating the effectiveness of the methods surveyed in this study it appears that there is a role for all three. Many drug abusers began their involvement in early adolescence while still in the stage of concrete thinking concerned only with the here and now. By escaping the learning experiences of adolescence through the medium of drugs, they never matured into the phase of functional behavior, (that is, thinking with the ability to plan ahead and the ability to consider others and their feelings). It is necessary for these people to undergo a new "adolescent period" even though their chronological age places them beyond this period. It is important to use the technique of repetition in a manner not unlike advertising, exposing them to drug-abuse counseling and information. When they are ready to use the product, sources and availability, this information will be known to them. Many prisoners who will not do well in the therapeutic community-type program can be subtly reached through other methods of counseling.

The in-prison therapeutic community is an excellent choice for many prisoners, and the classification officers are quite adept in selecting inmates for this program. At some institutions, in-patient communities create a conflict of choice between the program and work release or gain-time, influencing prisoners to bypass the in-prison

therapeutic community. It would be helpful if the criteria for admission were changed to allow prisoners at the early stages of their sentence to be admitted to a program. Another deficiency is lack of a reentry phase upon completion of the program. Graduates can only be returned to prison, released outright or transferred to one of the community-based programs. They cannot learn outside responsibility while still in the program. It is hoped that these problems can be solved in the near future.

The community-based programs are doing an excellent job for the Department of Corrections. They have overcome some of the deficiencies previously mentioned. In addition, they have the facilities for better long-term followup. Prisoners are unwilling to keep in touch with the prison system after discharge, whereas they look upon the therapeutic community with gratitude and will return for various functions thus providing continuing followup statistics. Parenthetically, I wish to state that the various therapeutic communities which I visited were able to provide followups and excellent results in approximately 90% of the graduates of the prison program. Of course, these were carefully screened individuals, but it does demonstrate what can be accomplished in the treatment of drug abuse and an analysis of the results.

Before summarizing, it is important to discuss other problems. One is the funding of various programs and the other legislative and public attitudes toward prisoners. Confining individuals in secure prisons is expensive. Many millions of dollars are expended simply to keep the 20,000 offenders of the streets. In the current mood of the public regarding spending by the legislature, funds for programs other than "lock-em-up" are not highly regarded. Rehabilitation programs such as drug abuse, eductional, vocational, recreational and others are not deemed of great importance to the funders. The general public is more concerned with law and order and less educated about the rehabilitation of prisoners. Programs instituted by the Department of Corrections, which appears to be quite concerned with rehabilitation, are up for legislative review with an apparent mandate to reduce spending. In view of the increasing prison population, decreased funding can only mean more elimination of programs designed for prisoner rehabilitation. This seems shortsighted and will do little toward reducing recidivism. Hopefully, the legislature will arrive at the best decision for the people of Florida. Prison drug abuse counselors feel that there is a lack of communication within the system. There is a dearth of followup reports and contact between the counselors from the different institutions. Regular meetings would be beneficial.

Summary

An overview of drug abuse treatment in the correctional institutions of Florida has been presented. The problems of rehabilitation and use of public funds to the greatest benefit have been discussed. An accurate measure of the success of the programs in force would entail a well-funded research program. It is hoped that this limited survey will lead to the appointment of a commission, properly funded, to explore prisoner rehabilitation in more detail with the development of concrete recommendations for the future. This study should investigate the effectiveness of each type of program as well as analyze the ratio of cost to success in each program.

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Silastic Overlay in the Treatment of Painful Neuromata

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Neuromata are sometimes troublesome to patients and can severely compromise the normal use of a hand so afflicted. "Amputation neuroma" was first described by Odier[1] in 1811, and first accurately described by Wood[2] in 1829. These can usually be treated by reapproximation of the severed nerve ends or by repositioning them in a less traumatized area.[3,4] Many other methods have been described, such as synthetic resin caps,[5] plastic and rubber tubing,[6] the use of tantalum wire and foil,[7] monomolecular filter tubes,[8] and silicone caps[9,10] with varying degrees of success. The silicone caps as described by Swanson, Boeve and Lumsden have been successful,[10] but we have been hesitant in placing them in areas adjacent to bone. In 17 cases over the past 22 months we have found that a double layer .005" silastic overlay works well in ameliorating the painful symptoms of a neuroma. The silastic is doubled and cut to a postage stamp size, placed directly over the neuroma and sutured at each corner for stability. The neuroma is not sandwiched between the layers of silastic; both layers are directly over the neuroma and superficial to it. Multiple neuromata can be covered simultaneously without producing any contour abnormality. These 17 cases have been followed for 22 months to three months. All cases had a well localized Tinel's sign pre-operatively. The cases include severance of the dorsal sensory branch of the radial nerve during surgery for DeQuervain's disease, severance of the dorsal sensory branch of the ulnar nerve during Darrach's procedure, severance of the dorsal sensory branch of the radial digital sensory nerve secondary to brown reclusive spider bite, iatrogenic and accidental amputations of the fingers and metacarpals. (See Chart #1). All operations were done as secondary procedures where open wounds were not present. The neuromata therefore were left intact, but in a number of cases a neurolysis was carried out to free the nerve from surrounding cicatrix. There have been no infections, bursa formation or other complications and none of the silastic overlays have been removed.



Fig. 1. — Position of neuroma marked out secondary to brown recluse spider bite.

The patients were all asked to give an estimate of the percentage improvement they obtained post-operatively. This averaged 90% improvement over the pre-operative condition. All patients were glad that they had had the operation and most were able to use the hand in ways that pre-operatively had been painfully impossible (such as holding a pencil, as in the brown recluse spider bite). (See Chart #1 and Figures 1, 2, and 3). In an attempt to quantitate improvement, the last three patients have been evaluated with a tonometer (used by opthamolo-

The Authors

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gists to test for glaucoma) maximally loaded pre-operatively and a Tinel's sign could be elicited. Using the same tonometer post-operatively a Tinel's sign could not be elicited. We do not know what the exact mechanism of action of the two layer silastic overlay is, but guess it is due to absorption and redistribution of force. We are at present investigating this with silastic overlays of sciatic nerves of rats, and findings will subsequently be published.

This technique has been found to give predictably good results with relief of incapacitating pre-operative neuromatous symptoms. (See Chart #1). There have been no complications. No secondary procedures have been necessary. Two patients have not been able to return to previous vocations or avocations, the remainder have been able to do so. One can elicit a Tinel's sign post-operatively, but a very strong percussive force is

Chart #1

Patient	Cause	Nerve (Digital)	Age	Pain		Return to Work	Patient Satisfaction	Follow up (months)
				Before	After			
RS	Laceration	Ulnar	25	Severe	0	+	Excellent	10
JH	Neuritis	Ulnar of forearm and palm	35	Severe	Moderate	—	Good	14
CS	Laceration	Radial	53	Severe	0	+	Excellent	22
ST	Laceration	Radial of toe	18	Moderate	0	+	Excellent	12
JT	Severed at surgery for DeQuervain's	Radial	50	Severe	0	+	Excellent	8
LJ	Crush of thumb	Ulnar	40	Severe	Moderate	+	Good	8
SS	Brown recluse spider bite	Radial	62	Severe	0	+	Excellent	8
RJ	Glove avulsion	Sensory of long, ring and little in palm	25	Severe	0	+	Excellent	13
JR	Laceration	Digital in palm	53	Severe	0	—	Excellent	14
BS	Previous Tumor	Radial	31	Severe	0	+	Excellent	19
EC	Amputation	Radial and Ulnar	35	Severe	0	+	Excellent	10
SC	Fracture and laceration	Radial	16	Severe	Minimal	+	Good	7
EJ	Crush	Radial	56	Severe	Minimal	+	Excellent	5
LD	Crush laceration	Radial	26	Moderate	0	+	Excellent	6
BW	Severed at surgery for DeQuervain's	Radial	36	Severe	0	+	Excellent	4
RS	Crush	Ulnar	36	Severe	0	+	Good	3
KF	Burn	Radial and Ulnar	22	Severe	Minimal	+	Good	3



Fig. 2. — Neuroma dissected out.



Fig. 3. — Silastic overlay inserted. Post-operatively patient able to use pencil and do other manual functions with index finger which had not been possible pre-operatively. Maximally loaded tonometer easily elicited Tinel's sign pre-operatively which could not be elicited when similarly tested post-operatively.

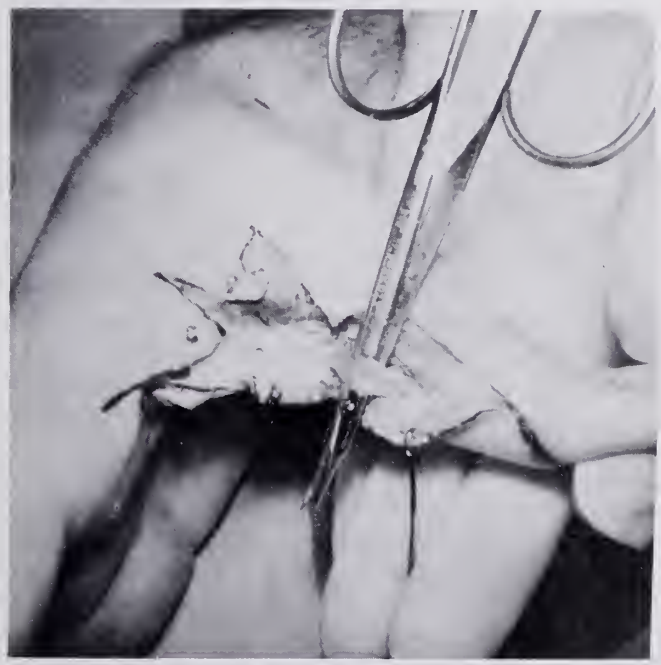


Fig. 4. — Post-traumatic neuroma of dorsal sensory branch of thumb. Concomitant adduction contracture of thumb being released with a four-flap Z-plasty.



Fig. 5. — Silastic overlay inserted. A few punctate marks placed on silastic overlay to increase visability.



Fig. 6. — Wound closed and four-flap Z-plasty interdigitated. Post-operatively patient able to use thumb without evoking neuroma pain. At three months patient could play 18 games of raquet ball a day without difficulty, although pre-operatively he could not grip a raquet without pain.

necessary.

The patients have been pleased with the results and we have been relieved and gratified to see a high percentage of them using their hands normally again.

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● Dr. Snow, 2345 Forbes Street, Jacksonville 32204.

ORGANIZATION

In-House Peer Review Screening by Blue Cross and Blue Shield of Florida

Richard C. Dever, M.D.

Blue Cross and Blue Shield of Florida, as Medicare Part B Carrier for all of Florida except Dade and Monroe Counties, is required under its contract with the U.S. Department of Health and Human Services to screen all physicians for possible overutilization of medical services to Medicare beneficiaries. Where suspected overutilization is detected, the Carrier assembles a file and if appropriate, makes a referral to the Florida Medical Foundation for an advisory opinion as to whether or not overutilization of services has occurred.

In order to accomplish this screening, a computer program has been set up which sorts all of the services, assigned or unassigned, that each physician or his patient bills to Medicare. Norms for frequencies of services are developed for each specialty listing on our provider file and the individual physician is compared to these norms for all practitioners of similar specialty in our area of jurisdiction. Where his individual frequencies of services vary significantly from those of his peers, an exception is noted on the profile. Some indication of the amount of his apparent deviation from the statewide norm is gained by the computer's calculation of a number which we refer to as a "weight". The larger this "weight" is, the further from the norm his practice appears to be to the computer.

Once these abberrant practitioners are identified the profiles are reviewed by the Carrier's full-time medical staff. Often these apparent deviations from the norms are explainable by virtue of information we have from our knowledge of the type of practice the physician has. Sometimes his actual type of practice may deviate from the specialty he has indicated to us in the past to be his specialty. Where the apparent deviation can be justified in this fashion, the file is closed.

When the carrier consultants cannot justify the pattern of practice, another computer program is utilized to sample the physician's practice in whatever location of service the problem appears, i.e., office, hospital, skilled nursing facility, home, and nursing home. This sample is selected by a random number technique and provides a statistically valid stratified sample of 7% of his total practice. In no case is a sample smaller than 30 patients selected. The sample has a confidence factor of 95%.

All claims for all of the sample patients are assembled and reviewed by analysts and our consultants and full-time staff. Where review of the claim information alone justifies the pattern of practice, the file is closed. Where the pattern cannot be explained on review of claim information only, the physician is requested to provide copies of medical records appropriate to the services billed.

As records are received they are integrated into the files and a subcommittee of practicing physicians (not including the Carrier's full-time staff) reviews the file and makes a recommendation to refer the case to the Florida Medical Foundation for Peer Medical Utilization Review, to close the file, or to take other measures to correct faulty billing practices or otherwise educate the physician where appropriate.

If the physician elects not to provide records, the file is referred to the Florida Medical Foundation which then can determine if the physician wishes to provide records and avail himself of his privilege in participation in the Peer Review process, a voluntary procedure.

Upon referral to the Foundation the entire file with medical records is sent to the Foundation for preliminary review as to acceptance and transmittal to a County Society Peer Review Committee.

Blue Cross and Blue Shield strongly feel that the Peer Review process is the best method extant of determining the pattern of practice of physicians and reaching a decision as to the medical necessity and reasonableness

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This is another in a series of monthly articles prepared under the auspices of the FMA Committee on Peer Medical Utilization Review.

Dr. Dever is Vice-President-Medical Affairs of Blue Cross and Blue Shield of Florida, Jacksonville.

of services provided to beneficiaries of the Medicare Program. The physician whose practice has been screened out has the best possible opportunity to justify his pattern of services when meeting with his peers to discuss the clinical work carried out during the year in question.

First Scientific Programs Are Announced For 107th Annual FMA Meeting

Four specialty groups have announced their scientific section programs for the 107th Annual Meeting of the Florida Medical Association, according to Calvin W. Martin, M.D., of Arcadia, Vice Chairman of the FMA Committee on Continuing Medical Education in charge of the program.

Dr. Martin said the Section on Chest Medicine will be conducted on Thursday afternoon, April 30, under the sponsorship of the Florida Thoracic Society and the Florida Chapter, American College of Chest Physicians. This will be followed on Friday by the Sections on Nuclear Medicine and Preventive Medicine and on Saturday by the Section on Urology.

Florida's three medical schools have been invited to join with FMA in sponsoring the program, Dr. Martin said. Application will be made to the Medical Education Committee of the Florida Medical Foundation for 20 hours of American Medical Association Category I Credit.

The convention will open at the Diplomat Hotel in Hollywood on Wednesday, April 29, 1981. It will end with adjournment of the third session of the policy-making House of Delegates on Sunday, May 3.

The following programs have been announced (others will be announced in future issues of *The Journal):*

THURSDAY AFTERNOON, APRIL 30

SECTION ON CHEST MEDICINE

(Co-sponsored by Florida Chapter, American College of Chest Physicians, and Florida Thoracic Society)
1:00 p.m. to 5:00 p.m.
James W. Wynne, M.D., Gainesville
Program Chairman

"New Diagnostic Techniques in Chest Medicine"

"Two-dimensional Echocardiography" — Walter Henry, M.D., Professor of Medicine and Chief, Division of Cardiology, University of California, Irvine, Calif.

"CAT Scanning of the Chest" — Lawrence R. Muroff, M.D., Director of Nuclear Medicine and Computer Tomography, University Community Hospital, and Clinical Associate Professor of Radiology, University of South Florida College of Medicine, Tampa.

"Nuclear Medicine Techniques for Assessment of Right and Left Ventricular Performance" — Stuart Gottlieb, M.D.. Clinical Associate Professor of Radiology, University of Miami School of Medicine, Miami.

"Thoracoscopy in the Diagnosis of Chest Disease" — Bradley Rodgers, M.D., Professor of Surgery and Pediatrics, University of Florida College of Medicine, Gainesville.

FRIDAY MORNING, MAY 1

SECTION ON NUCLEAR MEDICINE

(Co-sponsored by Florida Association of Nuclear Physicians)
8:00 a.m. to 10:45 a.m.
Mukbil Hourani, M.D., Miami
Program Chairman

"RIA Evaluation of Hepato Biliary Dysfunction" — Fuad Ashkar, M.D., Miami.

"Hepato Biliary Imaging" — Mukbil Hourani, M.D., Assistant Professor, Nuclear Medicine, Jackson Memorial Hospital, Miami.

"CEA Radio Immuno Assay" — (Speaker to be announced)

"GI Tract Imaging" — George Sfakianakis, M.D., Associate Professor of Radiology, Division of Nuclear Medicine, University of Miami School of Medicine, Miami.

FRIDAY AFTERNOON, MAY 1

SECTION ON PREVENTIVE MEDICINE

(Co-sponsored by Florida Society for Preventive Medicine)
2:00 p.m. to 5:30 p.m.
James T. Howell, M.D., Tallahassee
Program Chairman

"Overview of the Comprehensive Cancer Center" — C. Gordon Zubrod, M.D., Director, Comprehensive Cancer Center for the State of Florida, Miami.

"Control Activities of the Center" — Peter W. A. Mansell, M.D., Chief of Education and Training, Comprehensive Cancer Center for the State of Florida, Miami.

"Florida Cancer Data System" — Burton Siebert, Ph.D., Project Director, Division of Biostatistics, Comprehensive Cancer Center for the State of Florida, Miami.

"State of Florida's Public Health" — James T. Howell, M.D., State Health Officer and Staff Director, Health Program Office, Tallahassee.

"Update Infectious Diseases — State of Florida" — Robert A. Gunn, M.D., State Epidemiologist, Tallahassee.

SATURDAY MORNING, MAY 2

SECTION ON UROLOGY

(Co-sponsored by Florida Urological Society)
8:30 a.m. to 11:15 a.m.
Marvin J. Bondhus, M.D., Miami
Program Chairman

"Seminar on Urinary Tract Lithiasis" — Marvin J. Bondhus, M.D., Department of Urology, Jackson Memorial Hospital, Miami, Moderator.

Milton P. Coplan Pyelogram Hour — Richard B. Moore, M.D., West Palm Beach, Chairman.

Four FMA Members Are Elected To State Legislature

Four members of the Florida Medical Association were elected to seats in the Florida House of Representatives in the 1980 elections.

Republican Bernard Kimmel, M.D., won his first two-year term by ousting incumbent Representative Gene Campbell in Palm Beach County's District 82 race. He will join veteran Democrats Richard S. Hodes, M.D., of Tampa, and David J. Lehman, M.D., of Hollywood; and Republican William G. Myers, M.D., of Hobe Sound.

Dr. Kimmel is a former President of the Palm Beach County Medical Society and the Florida Academy of Family Physicians. A 1956 graduate of the University of Michigan School of Medicine, he served on the Palm Beach County School Board from 1972 to 1980, when he resigned as Chairman to seek the House seat.

Dr. Hodes, Dean of the Florida House of Representatives, was elected to his eighth consecutive two-year term. An anesthesiologist, he is a former President of the Hillsborough County Medical Association, the Florida Medical Association, and the National Conference of State Legislatures.

First elected to the House in 1974, Dr. Lehman had no general election opposition. He won a new term with a first primary triumph over Judith A. Tozzi. The New Jersey native is a graduate of the University of Virginia Medical School.

Dr. Myers was elected to his second two-year term without opposition. He represents Martin County's District 77. The former Martin County commissioner is a native of Pennsylvania and attended the University of Pittsburgh School of Medicine.

Major Announcements Affect Leadership Of All Florida Medical Schools

Major announcements have been made in recent weeks affecting the top leadership of all three Florida medical schools.

In chronological order they were:

—William B. Deal, M.D., has returned to the University of Florida as Dean of the College of Medicine, a post he left earlier in the year.

—E. M. Papper, M.D., longtime Dean of the University of Miami School of Medicine, announced plans to retire next year.

—Andor Szentivanyi, M.D., was named Dean of the College of Medicine and Director of the Medical Center at Tampa's University of South Florida, posts he had held on an acting basis since the resignation of Hollis G. Boren, M.D., several months ago.

University of Florida



William B. Deal, M.D.
Returns to Florida

Dr. Deal returned to the University of Florida four months after he had resigned as Dean and Vice President for Health Affairs to join the staff of the American Medical Association in Chicago. He said a major consideration in his decision to accept the invitation to return was the separation of the offices of Vice President and Dean.

Robert Q. Marston, M.D., President of the University, said Dr. Deal also will serve in the newly-created post of Associate Vice President for Clinical Affairs. Kenneth Finger, Ph.D., continues to serve as Acting Vice President for Health Affairs while a nationwide search continues for a permanent appointee.

University of Miami



E. M. Papper, M.D.
To Retire in 1981

Dr. Papper announced in November that he would retire as Vice President for Medical Affairs and Dean of the School of Medicine at the University of Miami on May 31, just before his 66th birthday. Dr. Papper, an internationally known medical educator, has held the posts since 1969.

UM President Henry King Stanford called Dr. Papper "one of the most distinguished appointments I have been able to make." President Stanford said his own successor will be announced about February 1 and he will consult with the new President regarding a committee to search for Dr. Papper's successor.

Upon Dr. Papper's retirement, Bernard J. Fogel, M.D., will become Interim Vice President and Dean.

"During his (Dr. Papper's) long tenure as Vice President and Dean, the School of Medicine has made enormous strides," Dr. Stanford observed.

He listed accomplishments of the Papper administration as including an extraordinary increase in research activity; development of an effective working relationship with Jackson Memorial Hospital; recruitment of outstanding clinicians and researchers to the University; increase in undergraduate enrollment in the School of Medicine from 305 to 646; attraction of a Comprehensive Cancer Center; establishment of a Ph.D. to M.D. curriculum; creation of several new clinical departments, including family medicine, oncology, epidemiology and public health; and affiliation with the National Parkinson Foundation; and completion of 26,000 square feet of

neuroscience research space to investigate Parkinson's Disease and other neurological disorders.

University of South Florida



Andor Szentivanyi, M.D.
Gets USF Appointment

At the University of South Florida, Dr. Szentivanyi was the unanimous choice of the search committee, which considered 86 candidates for the post. The new Director and Dean is a member of the College of Medicine's original faculty, joining the College in 1970 as Professor and Chairman of Pharmacology and Therapeutics.

He graduated with honors from the University Medical School at Debrecen in his native Hungary. He was on the faculty of the University Medical School in Budapest until the Communist takeover in 1956, when he and his wife and their six-year-old son fled the country.

In the United States he has held positions at the University of Chicago, the University of Colorado and Creighton University.

Dr. Szentivanyi, whose wife Judith is also a physician, is an acknowledged leader in immunopharmacology and asthma research. He has written more than 200 pieces of literature for publication and is on the editorial boards of five international scientific journals.

JCAH Hotline Implemented

The Joint Commission on Accreditation of Hospitals (JCAH) has implemented a 24-hour, national Hotline to provide timely responses to inquiries about JCAH and the accreditation process.

A Hotline operator will be available from 8 a.m. to 5 p.m., Central Time, Monday through Friday. Calls received at all other times will be recorded, transcribed and returned the next working day. The Hotline number is 1-800-621-8007 (in Illinois 1-800-572-8089).

1981 PLI Coverage and Premiums

Editor's Note: The following letter was sent to all physicians insured by the Florida Physicians' Insurance Reciprocal. The subject, 1981 coverage and premiums, should be of interest to all Florida physicians.

Your Reciprocal is sound financially; however, since we started our malpractice insurance program on December 1, 1975, the number of claims has tripled and severity has doubled.

There has not been a premium increase since we sold our first policy, and to remain stable, there must be an across-the-board increase in premium of 20 percent for 1981. The premium disparity (surcharge) for Dade and Broward Counties is being reduced from 1.60 to 1.45, so these physicians will have less than a 20 percent increase. This is not due to improvements in Dade and Broward Counties but to more claims and increased severity in the remainder of the state.

Emergency Department Physicians will have a 50 percent surcharge on their premiums due to the excessive loss experience in this specialty.

The tragic loss of mediation panels in Florida due to the Florida Supreme Court ruling in February of this year has hopefully been offset by the Recovery of Cost Law, in malpractice suits, enacted by the Florida Legislature this past spring.

Our reinsurers (Lloyd's of London and others) are still solidly behind us, and our treaty has been finalized for 1981. They observe another serious crisis coming in America in the next couple of years but believe our Reciprocal can weather the storm if we are prudent and plan ahead.

Your Reciprocal Board of Directors last month adopted the following priorities:

1. An intensive mandatory malpractice prevention program in cooperation with the Florida Medical Association's county medical societies, specialty groups, annual meeting, and Florida hospital staff meetings;
2. A greater emphasis placed upon legal aggressiveness in defense of all nonmeritorious suits with regional coordination of legal counsel;
3. Increased emphasis placed upon the claims handling, particularly of small claims in an effort for them to be disposed of more expeditiously and efficiently;
4. A more aggressive investment policy (it was noted that the Reciprocal's investment in real estate has been most rewarding); and
5. A three-year plan of reinsurance in an effort to further stabilize the Reciprocal.

We have functioned efficiently for five years with the lowest overhead of any comparable company in America. However, our actuaries as well as the actuaries employed by the Lloyd's have studied the increase in both frequency and severity of claims and advised us of the future crisis alluded to above.

In spite of an increase in the cost of living of 10 to 20 percent annually since we began operating, we have not previously increased rates but have paid two dividends. We now must increase the premium to remain on a sound financial basis.

Your Board will continue to represent you in the most efficient manner possible.

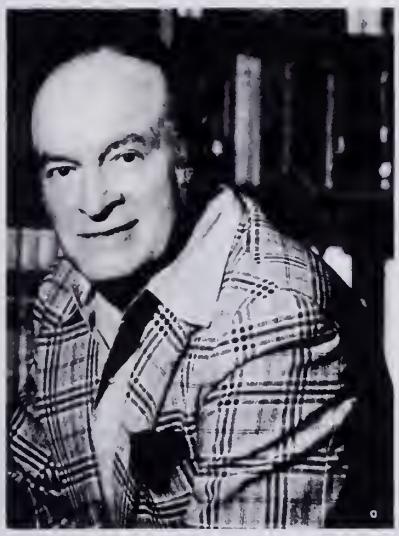
We wish to thank the many members of the Reciprocal who have assisted us in this past year as medical consultants with both underwriting and claims and to thank all 6,700 physicians who expressed their confidence in the Reciprocal by retaining their professional liability insurance coverage through the Reciprocal.

Sincerely,

Vernon B. Astler, M.D.
Chairman

W. Harold Parham, D.H.A.
Attorney-in-Fact/President

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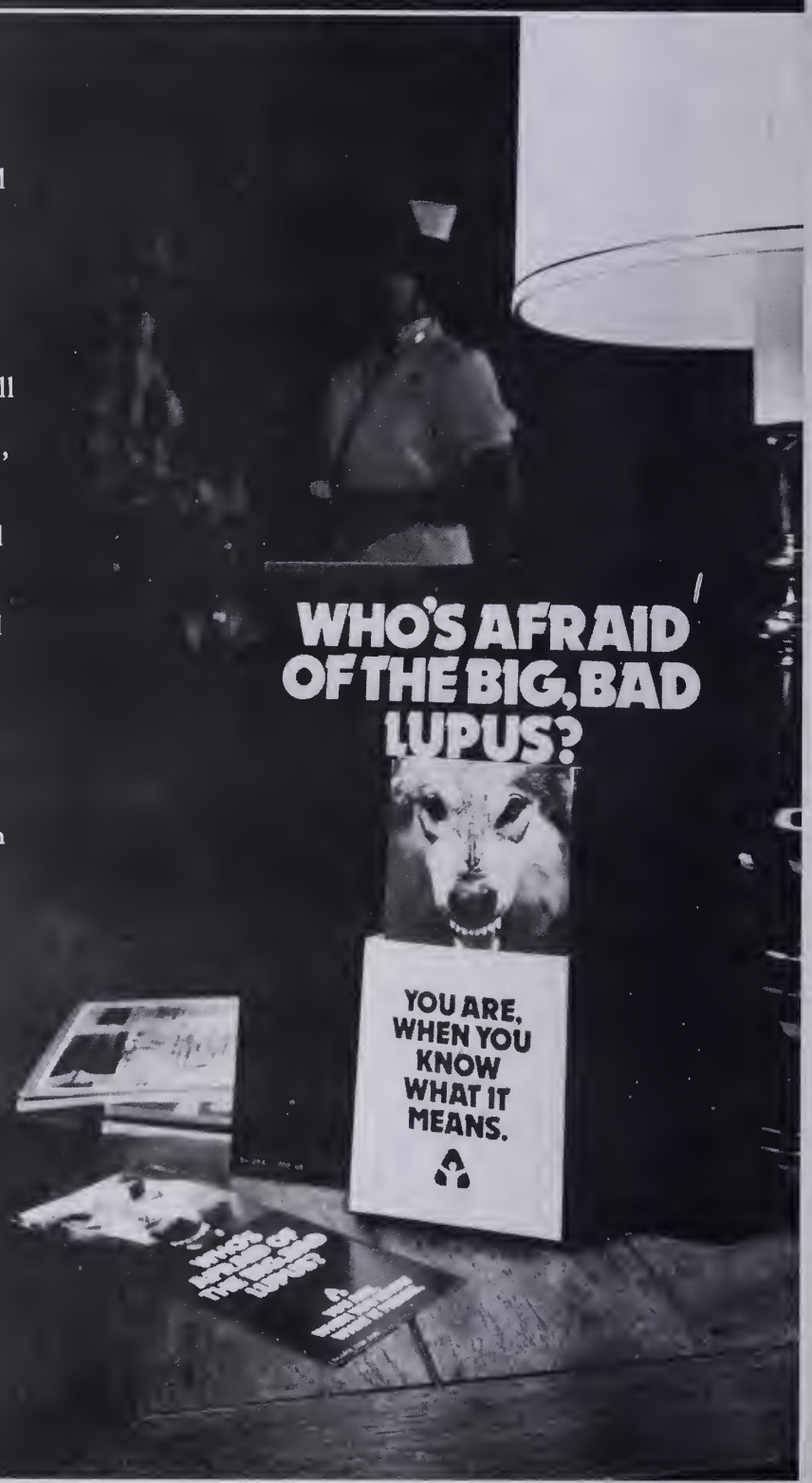
LUPUS FACTS
FOR YOUR PATIENTS

Lupus is the subject of a new Arthritis Foundation educational campaign.

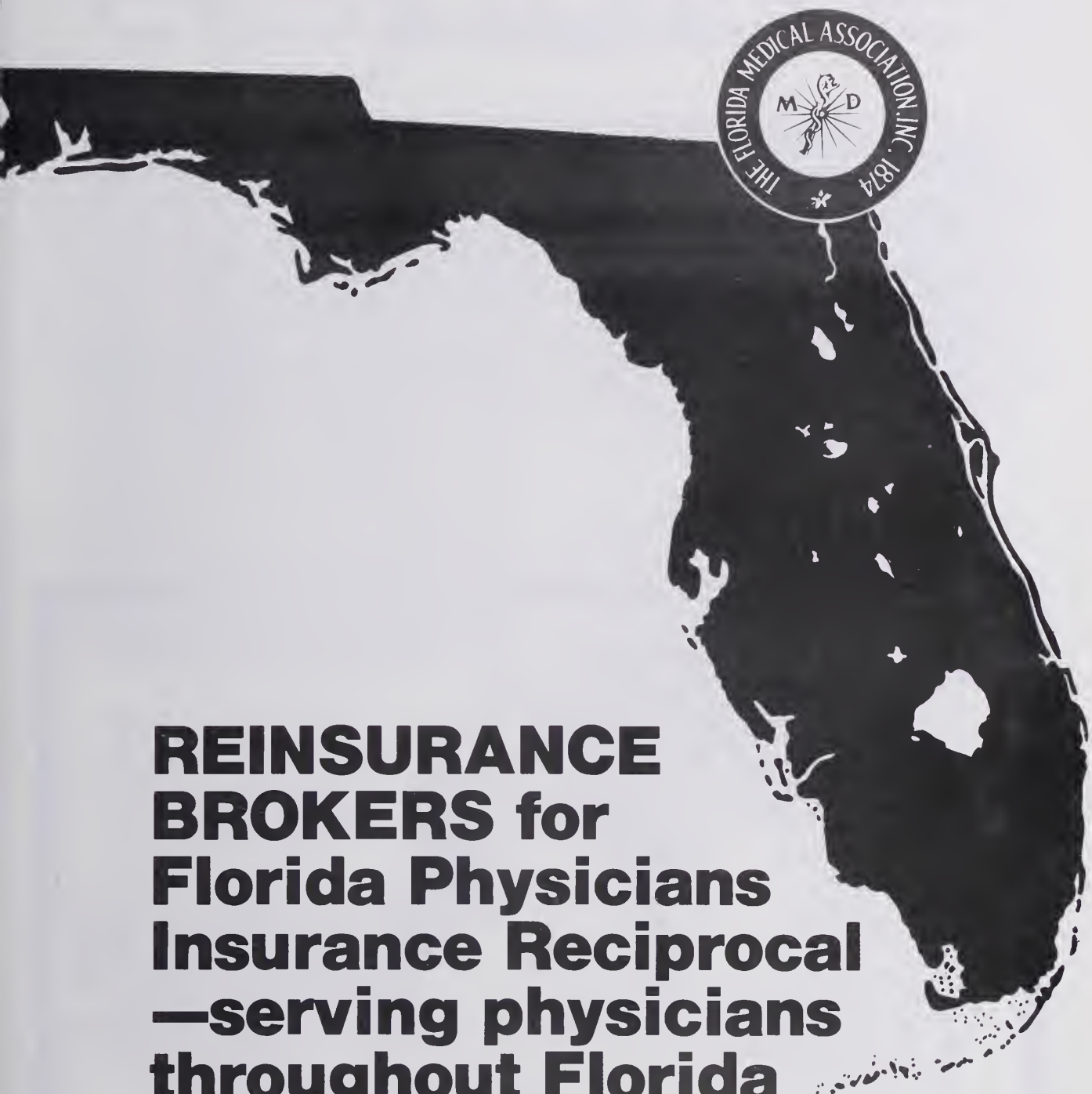
The campaign theme is: "WHO'S AFRAID OF THE BIG, BAD LUPUS?...YOU ARE WHEN YOU KNOW WHAT IT MEANS." Using a wolf as an attention getter, we will seek to inform the public about the LUPUS problem in the U.S., and the help that is available. Our literature will provide the warning signs for the disease and our consumer ads and broadcast materials will stress early diagnosis and proper medication and therapy, as the only defense.

We urge your participation in this effort. Our new fact-filled lupus brochure, written for the layman, covers such subjects as what is lupus, the diagnosis of lupus, who gets lupus, the pattern of lupus, signs and symptoms, a management/treatment program and prevention guidelines. Simply order the desired quantities from your local Arthritis Foundation Chapter office, or write "Lupus," Arthritis Foundation, 3400 Peachtree Road, NE, Atlanta, Georgia 30326.

With your help, the impact of this lupus educational campaign will be just what the doctor ordered.



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Fifty Years Ago

In *The Journal of the Florida Medical Association* for December 1930:

"Analgesia and Anesthesia in Obstetrics" appeared in the scientific section under the authorship of **A. D. Stollenwerck, M.D.**, of Jacksonville . . . More than 150 public health workers met in Jacksonville December 8-10 and formed the State Public Health Association. State Health Officer **Henry Hanson, M.D.**, was elected President . . . **T. M. Rivers, M.D.**, of Kissimmee, read a paper on "Arthritis with Special Reference to Cause" at the Orange County Medical Society meeting on November 19 . . . **H. E. Palmer, M.D.**, of Tallahassee, was elected President of the Tallahassee Kiwanis Club . . . **Frank Gray, M.D.**, of Orlando, attended the Florida-Georgia football game in Savannah . . . The Florida Association of Aviation Medical Examiners invited applications for associate membership . . . **Earnest B. Milam, M.D.**, of Jacksonville, spoke on "The Health of the Business Woman" at a meeting of the Business and Professional Woman's Club at Jacksonville's George Washington Hotel . . . **Milton M. Coplan, M.D.**, was among Florida physicians registered for the 24th Annual Meeting of the Florida Medical Association in Louisville . . .

And so it was in Florida medicine 50 years ago this month. — E.D.H.

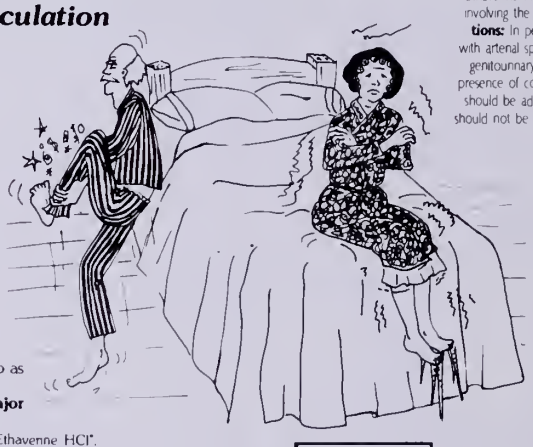
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* William J Oswald, M D . "Pharmacology of Ethavenne HCl". *Southern Medical Journal*, December 1975 - Vol 68, No 12



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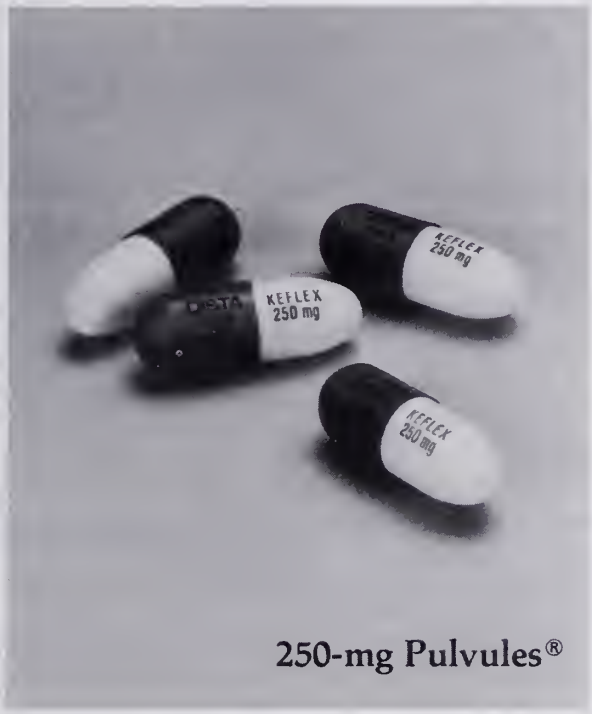
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Twenty-Five Years Ago

In *The Journal of the Florida Medical Association* for December 1955:

The lead scientific article was entitled "The State Narcotic Patient at the Florida State Prison," contributed by **Mark E. Adams, M.D.**, of Raiford . . . Total registration for the four Medical District meetings in October was 323 plus 59 visitors . . . New FMA members reported this month included **Charles J. Kahn, M.D.**, of Pensacola, later to become Speaker of the FMA House of Delegates, and **Edward W. St. Mary, M.D.**, who many years later would edit *Miami Medicine* . . . **Lorenzo L. Parks, M.D.**, of Jacksonville, was elected President of the Florida Public Health Association . . .

And so it was in Florida medicine 25 years ago this month. — E.D.H.

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The Suncoast Gerontology Center . . . of the University of South Florida Medical Center has received a five-year federal grant of $2.5 million, the largest grant in USF's history.

The funds, from the Commission on Aging, will finance the education of health professionals providing services to older Americans, research and clinical services.

Eric Pfeiffer, M.D., Professor of Psychiatry in the USF College of Medicine, is Director of the Center, whose service area covers Hillsborough, Manatee, Pasco and Pinellas Counties.

J. Lee Dockery, M.D. . . . of Gainesville, has been appointed to the American Medical Association's Advisory Panel on Bioethics.

The panel will make recommendations on ethical questions which arise from developments in medical science and technology. Topics to be evaluated include genetic research, fetal research, human experimentation, terminal illness and artificial insemination.

Dr. Dockery is Associate Dean of the University of Florida College of Medicine and a member of the Executive Committee of the Florida Medical Association.

Gwendolyn S. Connor, M.D. . . . of Winter Haven, has been re-elected Assistant Secretary of the 16,800-member American Society of Anesthesiologists. She is Chairman of Anesthesiology at Winter Haven Hospital and is Chairman of the ASA Committee on Membership and Credentials.

N. Harry Carpenter, M.D. . . . of Fort Lauderdale, has been elected a Fellow of the American College of Preventive Medicine.



Dr. Gasset



Dr. Forster

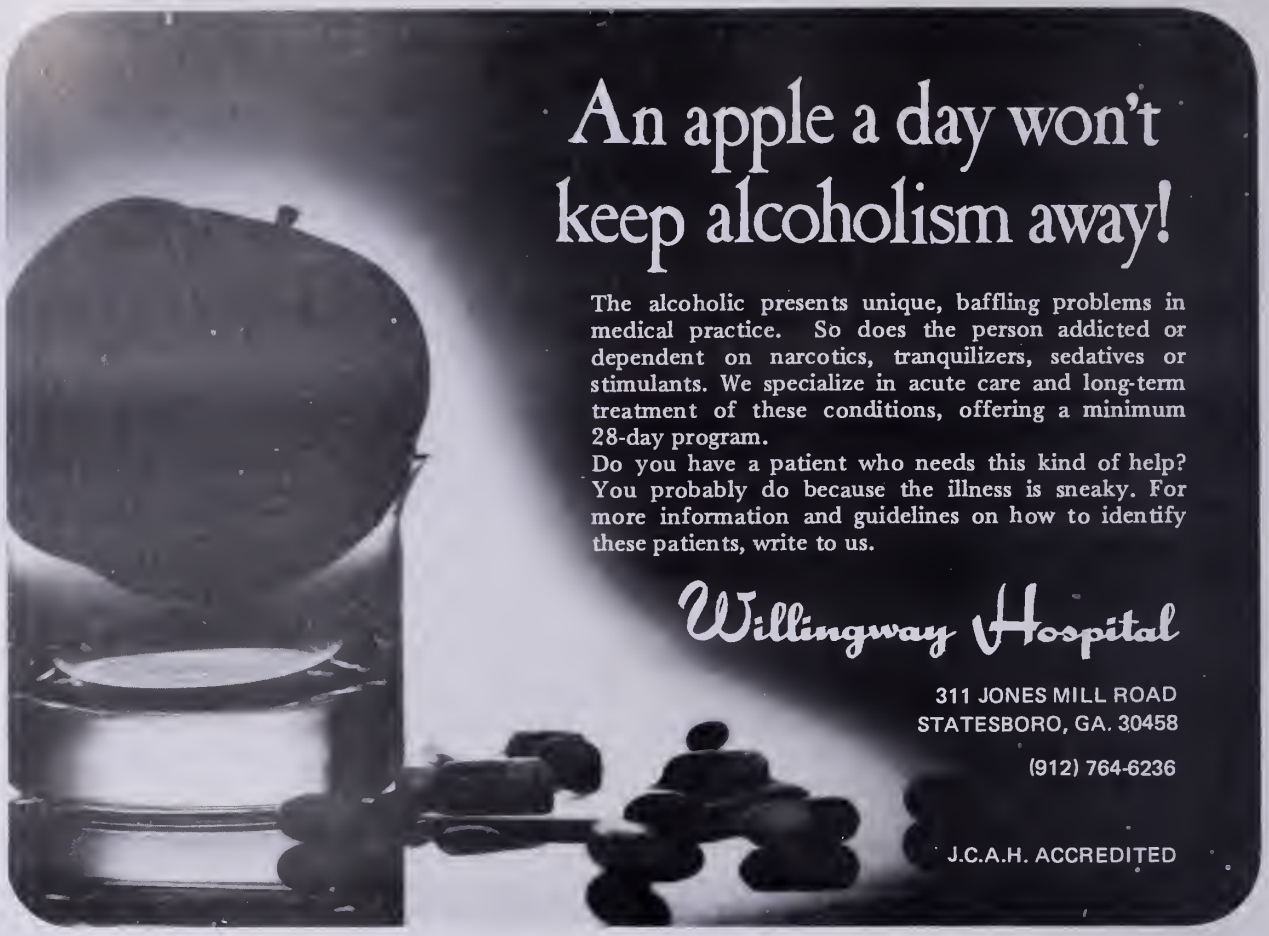
Antonio R. Gasset, M.D. . . . Chairman of the Department of Ophthalmology at American Hospital of Miami, and **Richard K. Forster, M.D.**, Associate Professor of Ophthalmology at the University of Miami School of Medicine have received the American Academy of Ophthalmology's 1980 Honor Award for outstanding service to the profession.

The awards, presented at the Academy's Annual Meeting in Chicago in November, recognized contributions to continuing education made by Dr. Gasset and Dr. Forster. Dr. Gasset's educational activities include service on the editorial boards of *International Contact Lens Clinic* and the *Annals of Ophthalmology;* several contributions to the literature on contact lenses; and conducting a course on contact lenses at the Academy's Annual Meeting.

Dr. Gasset is a graduate of Boston University School of Medicine and is a Diplomate of the American Board of Ophthalmology. He formerly was an Associate Professor of Ophthalmology at the University of Florida College of Medicine, where he completed his residency.

Dr. Forster is a member of the board of governors and chairman of several committees at the Bascom Palmer Eye Institute/Anne Bates Leach Eye Hospital. He is a board member of the Miami Lighthouse for the Blind and associated with Florida Lions Eye Bank. In connection with his participation in the clinical activities of the latter, he coordinates a course for morticians in the sterile removal of donor eyes for corneal transplants. He has also conducted courses at the Academy's Annual Meeting.

Both writer and editor, Dr. Forster's papers appear in various medical journals, and he is periodically called upon to review and evaluate papers presented by others for publication in the *Archives of Ophthalmology* and *Investigative Ophthalmology*. He is currently involved in a National Institutes of Health sponsored research program. He is also a graduate of Boston University School of Medicine.



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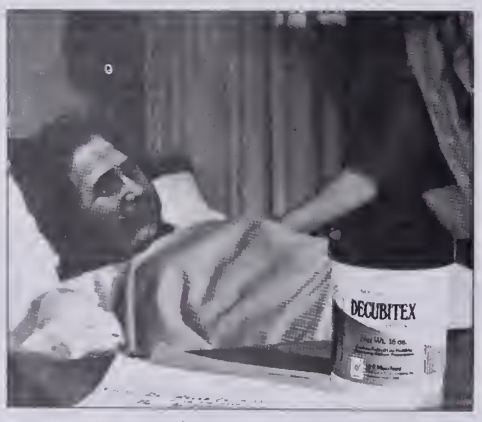
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FMA AUXILIARY

Auxiliary Presidents-Elect Gather

I had the pleasure of being one of the 250 county presidents-elect of the American Medical Association Auxiliary, and one of the 11 from Florida attending the 1980 Confluence at the Drake Hotel, October 5-7, in Chicago. Our state President Mrs. Fred Swing (Anne); President-Elect Mrs. Francis C. Coleman (Ruth); Mrs. B. David Epstein (Edie), our representative on the National Nominating Committee and RPMSS South Regional Chairman; and Mrs. Wanda McDermon, Executive Secretary to the FMA-A also attended.

Presidents-elect attending from Florida were Mrs. John Castelli (Barbara), Orange Park; Mrs. Al Deeb (May), Tallahassee; Mrs. Manuel Del Charco (Gerry), Ocala; Mrs. Arthur Eberly (Jane), Pompano Beach; Mrs. Joseph George (Beatrice), Miami; Mrs. Robert Hogue (Jeannine), Gainesville; Mrs. Thomas Holmes (Helen), Cantonment; Mrs. Morris LeVine (Marilyn), St. Petersburg; Mrs. Mark Mintz (Barbara), Cape Coral; Mrs. Calvin Mitchell (Joanne), Tampa; and Mrs. Charles Voorhis (Patt), Panama City.

Mrs. John Vaughan, President, presided at the opening dinner. Keynote Speaker was AMA President Robert B. Hunter, M.D. He discussed improved medicines, treatment modes and diagnostic techniques and machinery that have arrived on the scene over the past 20 years.

Each participant chose six of the 12 seminars offered. Six of these were designed to strengthen leadership abilities. Concepts of Leadership was the topic at a breakfast meeting. Michael J. McCarthy, Senior Consultant for Lawrence Leiter and Company, Management Consultants Kansas City, Mo. was the speaker. Other topics were Writing, Art and Layout, Parliamentary Procedure, Building Membership, Methods and Motivation, Management of Time, Techniques for Speakers and Assertiveness Training. Topic Seminars "Health and the Family" were offered and designed as potential community action programs or projects. These topics were Physical Fitness, Prescription Drug Abuse, Health Education in the Schools, Parenting, and Child Passenger Safety.

No AMA or AMA-A function would be complete without having James H. Sammons, M.D., Executive Vice President of the American Medical Association, as a speaker. Dr. Sammons spoke about the temporary suspension of the AMA-ERF student loan fund and said that it is under review.

I think every auxilian came away from Confluence with many new ideas and more self-confidence. We found that we have barely scratched the surface in the areas where we can be of service to our husbands' profession, or become a better parent, grandparent or a friend, and a better and wiser member of our community. We must and we can get involved and "Get Into the Act."

Mrs. Arthur (Jane) Eberly
President-Elect
Broward County Medical Association Auxiliary

THE MORTON F. PLANT HOSPITAL
AND
THE MORTON F. PLANT HEART CENTER

Announce

THE FIFTH ANNUAL CARDIOVASCULAR SYMPOSIUM

February 20-21, 1981

The Sheraton Sand Key Hotel — Clearwater Beach, Florida

The 5th Annual Cardiovascular Symposium is devoted primarily to selected topics relative to the diagnosis and management of atherosclerotic coronary heart disease. The natural history, clinical recognition, non-invasive and invasive evaluation, as well as the surgical and non-surgical management, will be presented in detail.

Special presentations will also deal with the importance of clinical subsets in the evaluation and management of patients with atherosclerotic coronary heart disease.

An outstanding faculty has been assembled for the symposium which should be of interest to all physicians caring for patients with cardiovascular disease.

GUEST FACULTY

Robert O. Brandenburg, M.D.	Rochester, Minnesota
Robert S. Eliot, M.D.	Omaha, Nebraska
Stephen E. Epstein, M.D.	Bethesda, Maryland
J. Willis Hurst, M.D.	Atlanta, Georgia
Henry J. L. Marriott, M.D.	St. Petersburg, Florida
Carl J. Pepine, M.D.	Gainesville, Florida
Barry D. Rutherford, M.D.	Kansas City, Missouri
Hugh C. Smith, M.D.	Rochester, Minnesota
Myron W. Wheat, Jr., M.D.	St. Petersburg-Clearwater, Florida

As an organization accredited for continuing medical education, the Medical Education Committee of the Florida Medical Foundation designates that this continuing medical education activity meets the criteria for 10½ credit hours in Category I of the Physicians' Recognition Award of the American Medical Association. This program meets the Florida Medical Association continuing medical education requirement for 10½ hours of Florida Medical Association Mandatory credit. This program has been reviewed and is acceptable for 10½ Prescribed hours by the American Academy of Family Physicians.

RESERVATION FEES:	$100 — all physicians $ 50 — all paramedical personnel (nurses, technicians, etc.)
HOTEL RESERVATIONS:	Contact the Sheraton Sand Key Hotel on Clearwater Beach Phone: (813) 595-1611
REGISTRATION:	Make checks payable to: Morton F. Plant Heart Center — Symposium Donald R. Eubanks, M.D. (813) 441-5166 Program Director 323 Jeffords Street Clearwater, Florida 33517

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Each capsule contains
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antianxiety/antisecretory/antispasmodic

for adjunctive therapy of duodenal ulcer* and irritable bowel syndrome*

Librax®

Please consult complete prescribing information, a summary of which follows:

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:
"Possibly" effective, as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis
Final classification of the less-than-effective indications requires further investigation

Contraindications: Glaucoma, prostatic hypertrophy, benign bladder neck obstruction, hypersensitivity to chlordiazepoxide HCl and/or clidinium Bromide

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl-Roche) to known addiction-prone individuals or those who might increase dosage, withdrawal symptoms (including convulsions) reported following discontinuation of the drug

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants, causal relationship not established.

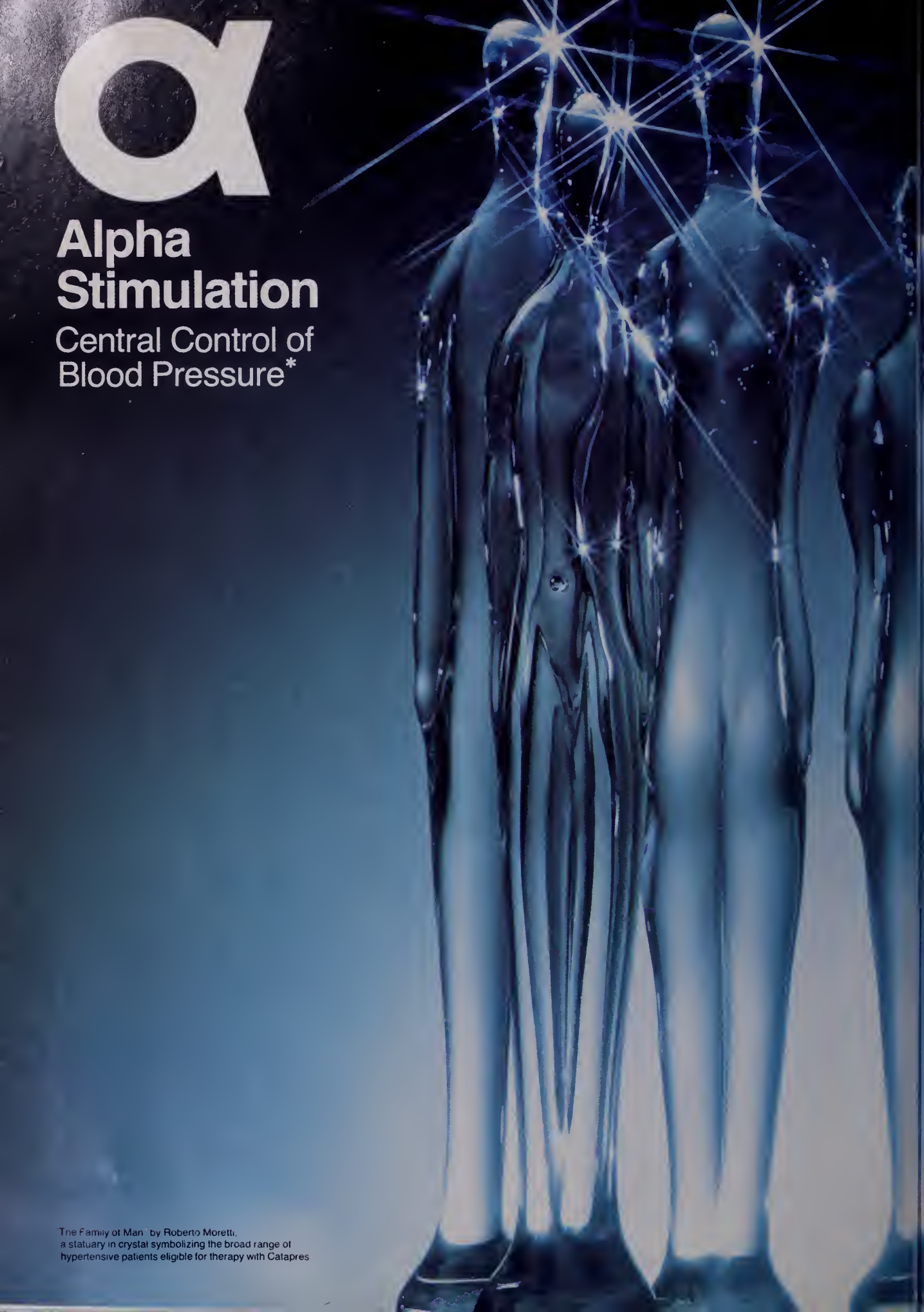
Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated, avoidable in most cases by proper dosage adjustment but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction, changes in EEG patterns may appear during and after treatment, blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and or low residue diets

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The Family of Man" by Roberto Moretti,
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The Alpha Advantage:

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Congestive heart failure	Allergic rhinitis
Ventricular hypertrophy	Hepatic disease
Hyperglycemia	Hyperuricemia
Diabetes mellitus	Gouty arthritis
Bronchial asthma	Sulfonamide hypersensitivity

Like any antihypertensive, use with caution in severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

work/play—normal hemodynamic responses to exercise maintained.

love—low incidence of impotence and/or loss of libido: 2.8% in 1,923 patients studied.[1]

cardiac output—tends to return to control values during long-term therapy.

blood flow—preserved in kidney.

No Single Advantage Determines Drug Choice.

Other factors must include:

The drug's effectiveness in a given patient, its side effects, warnings, precautions, tolerance, etc. A rational therapeutic choice depends on a careful assessment of all such factors.

*Central alpha-adrenergic stimulation decreases sympathetic outflow from the brain, as shown in animal studies.

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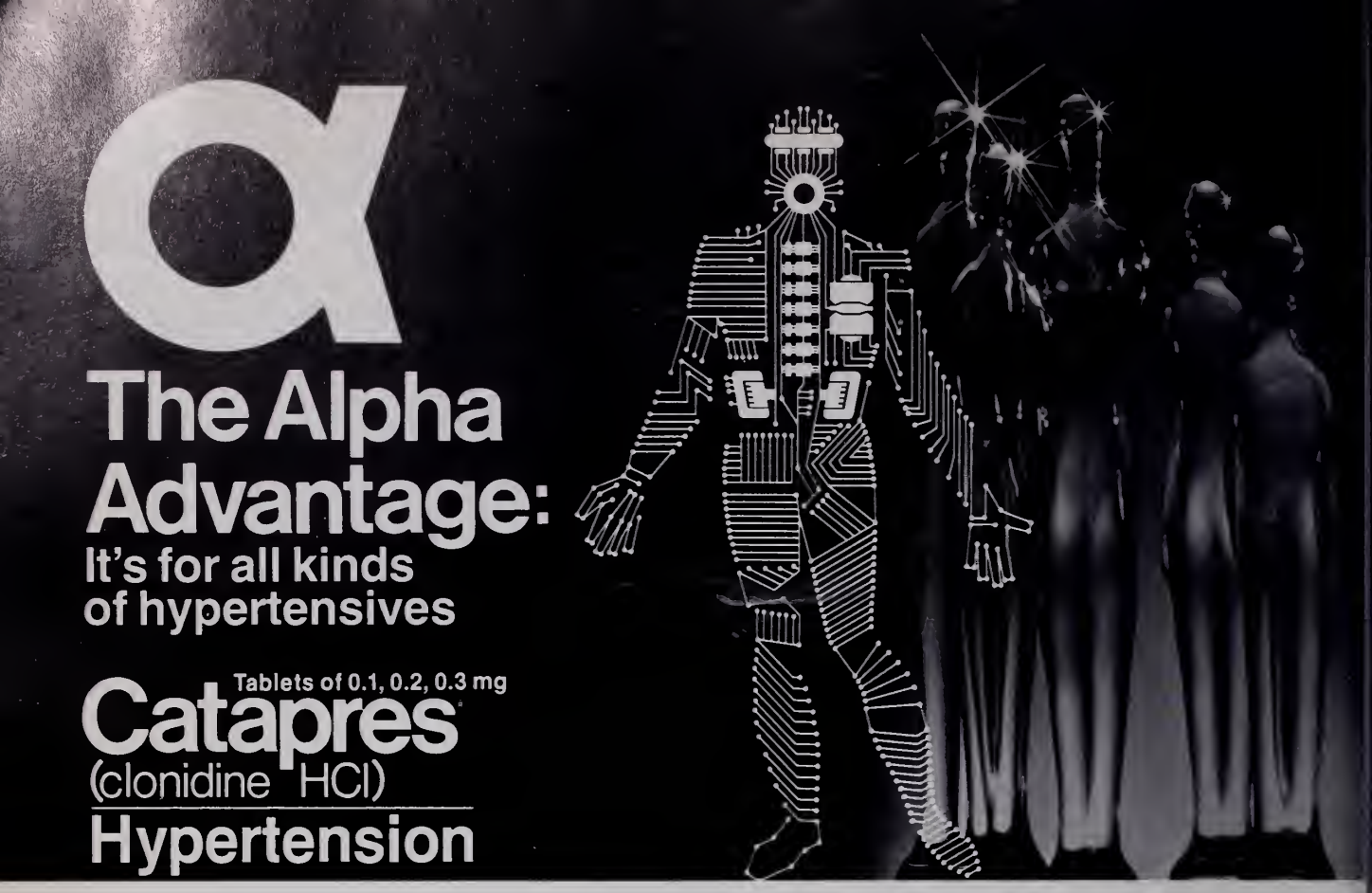
Please see last page for brief summary, including warnings, precautions, and adverse reactions.

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Catapres®
(clonidine HCl)
Hypertension



The Alpha Advantage:

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Catapres

(clonidine HCl)

Hypertension

- No contraindications.
- Effective in all degrees of hypertension. It is mild to moderate in potency.
- Low incidence of depression, impotence, orthostatic hypotension—no fatal hepatotoxicity.
- Preserves kidney blood flow.

Most common side effects are dry mouth, drowsiness, and sedation which generally tend to diminish with time.

The usual starting dose of Catapres is 0.1 mg at breakfast and 0.1 mg at bedtime. Some patients may benefit from a starting dose of 0.1 mg at bedtime.

Usual daily dose range—0.2—0.8 mg

Maximum daily dose—2.4 mg
Doses as high as this have rarely been employed.

For optimal results, the dose of Catapres must be adjusted according to the patient's individual blood pressure response.

Catapres®
(clonidine hydrochloride)
Tablets of 0.1, 0.2, 0.3 mg

Indication: The drug is indicated in the treatment of hypertension. As an antihypertensive drug, Catapres (clonidine hydrochloride) is mild to moderate in potency. It may be employed in a general treatment program with a diuretic and/or other antihypertensive agents as needed for proper patient response.

Warnings: Tolerance may develop in some patients necessitating a reevaluation of therapy.
Usage in Pregnancy: In view of embryotoxic findings in animals, and since information on possible adverse effects in pregnant women is limited to uncontrolled clinical data, the drug is not recommended in women who are or may become pregnant unless the potential benefits outweigh the potential risk to mother and fetus.
Usage in Children: No clinical experience is available with the use of Catapres (clonidine hydrochloride) in children.

Precautions: When discontinuing Catapres (clonidine hydrochloride), reduce the dose gradually over 2 to 4 days to avoid a possible rapid rise in blood pressure and associated subjective symptoms such as nervousness, agitation, and headache. Patients should be instructed not to discontinue therapy without consulting their physician. Rare instances of hypertensive encephalopathy and death have been recorded after cessation of clonidine hydrochloride therapy. A causal relationship has not been established in these cases. It has been demonstrated that an excessive rise in blood pressure, should it occur, can be reversed by resumption of clonidine hydrochloride therapy or by intravenous phentolamine. Patients who engage in potentially hazardous activities, such as operating machinery or driving, should be advised of the sedative effect. This drug may enhance the CNS-depressive effects of alcohol, barbiturates and other sedatives. Like any other agent lowering blood pressure, clonidine hydrochloride should be used with caution in patients with severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

As an integral part of their overall long-term care, patients treated with Catapres (clonidine hydrochloride) should receive periodic eye examinations. While, except for some dryness of the eyes, no drug-related abnormal ophthalmologic findings have been recorded with Catapres (clonidine hydrochloride), in several studies the drug produced a dose-dependent increase in the incidence and severity of spontaneously occurring retinal degeneration in albino rats treated for 6 months longer.

Adverse Reactions: The most common reactions are dry mouth, drowsiness a sedation. Constipation, dizziness, headache, and fatigue have been reporte Generally these effects tend to diminish with continued therapy. The followi reactions have been associated with the drug, some of them rarely. (In sor instances an exact causal relationship has not been established.) These inclu Anorexia, malaise, nausea, vomiting, parotid pain, mild transient abnormalities liver function tests; one report of possible drug-induced hepatitis without icter and hyperbilirubinemia in a patient receiving clonidine hydrochloride, chl thalidone and papaverine hydrochloride. Weight gain, transient elevation of blo glucose, or serum creatine phosphokinase: congestive heart failure, Raynau phenomenon; vivid dreams or nightmares, insomnia, other behavioral chang nervousness, restlessness, anxiety and mental depression. Also rash, a gioneurotic edema, hives, urticaria, thinning of the hair, pruritus not associat with a rash, impotence, urinary retention, increased sensitivity to alcohol, dryne itching or burning of the eyes, dryness of the nasal mucosa, pallor, gynecomast weakly positive Coombs' test, asymptomatic electrocardiographic abnormaliti manifested as Wenckebach period or ventricular trigeminy.

Overdosage: Profound hypotension, weakness, somnolence, diminished or a sent reflexes and vomiting followed the accidental ingestion of Catapres (clonidi hydrochloride) by several children from 19 months to 5 years of age. Gast lavage and administration of an analeptic and vasopressor led to complete r covery within 24 hours. Tolazoline in intravenous doses of 10 mg at 30-minu intervals usually abolishes all effects of Catapres, (clonidine hydrochloride) ov dosage.

How Supplied: Catapres, brand of clonidine hydrochloride, is available as 0.1 m (tan) and 0.2 mg (orange) oval, single-scored tablets in bottles of 100 and 1000. Al available as 0.3 mg (peach) oval, single-scored tablets in bottles of 100.

For complete details, please see full prescribing information.
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A non-narcotic one-two punch against pain, with concurrent relief of anxiety/tension

EQUAGESIC® ℂ

(meprobamate and ethoheptazine citrate with aspirin) Wyeth

EQUAGESIC—Abbreviated Summary

***INDICATIONS:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows

"Possibly" effective, for the treatment of pain accompanied by tension and/or anxiety in patients with musculoskeletal disease or tension headache

Final classification of the less-than-effective indications requires further investigation.

The effectiveness of Equagesic in long-term use, i.e. more than four months, has not been assessed by systematic clinical studies. The physician should periodically reassess usefulness of the drug for the individual patient

CONTRAINDICATIONS: Equagesic should not be given to individuals with a history of sensitivity or severe intolerance to aspirin, meprobamate, or ethoheptazine citrate

WARNINGS: Careful supervision of dose and amounts prescribed for patients is advised, especially with those patients with known propensity for taking excessive quantities of drugs Excessive and prolonged use in susceptible persons, e g., alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on or habituation to the drug Where excessive dosage has continued for weeks or months, dosage should be reduced gradually rather than abruptly stopped, since withdrawal of a "crutch" may precipitate withdrawal reaction of greater proportions than that for which the drug was originally prescribed Abrupt discontinuance of doses in excess of the recommended dose has resulted in some cases in the occurrence of epileptiform seizures

Special care should be taken to warn patients taking meprobamate that tolerance to alcohol may be lowered with resultant slowing of reaction time and impairment of judgement and coordination.

USAGE IN PREGNANCY AND LACTATION: An increased risk of congenital malformations associated with the use of minor tranquilizers (meprobamate, chlordiazepoxide, and diazepam) during the first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of child-bearing potential may be pregnant at the time of institution of therapy should be considered. Patients should be advised that if they become pregnant during therapy or intend to become pregnant they should communicate with their physicians about the desirability of discontinuing the drug.

Meprobamate passes the placental barrier. It is present both in umbilical-cord blood at or near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breast-feeding patients, the drug's higher concentrations in breast milk as compared to maternal plasma levels should be considered.

Preparations containing aspirin should be kept out of the reach of children. Equagesic is not recommended for patients 12 years of age and under

PRECAUTIONS: Should drowsiness, ataxia, or visual disturbance occur, the dose should be reduced. If symptoms continue, patients should not operate a motor vehicle or any dangerous machinery

Suicidal attempts with meprobamate have resulted in coma, shock, vasomotor and respiratory collapse, and anuria Very few suicidal attempts were fatal, although some patients ingested very large amounts of the drug (20 to 40 gm) These doses are much greater than recommended The drug should be given cautiously, and in small amounts, to patients who have suicidal tendencies In cases where excessive doses have been taken, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels Hyperventilation has been reported occasionally Any drug remaining in the stomach should be removed and symptomatic treatment given Should respiration become very shallow and slow, CNS stimulants, e g , caffeine, Metrazol, or amphetamine, may be cautiously administered If severe hypotension develops, pressor amines should be used parenterally to restore blood pressure to normal levels.

ADVERSE REACTIONS: A small percentage of patients may experience nausea with or without vomiting and epigastric distress Dizziness occurs rarely when meprobamate and ethoheptazine citrate with aspirin is administered in recommended dosage The meprobamate may cause drowsiness but, as a rule, this disappears as therapy is continued Should drowsiness persist and be associated with ataxia, this symptom can usually be controlled by decreasing the dose, but occasionally it may be desirable to administer central stimulants such as amphetamine or mephentermine sulfate concomitantly to control drowsiness

A clearly related side effect to the administration of meprobamate is the rare occurrence of allergic or idiosyncratic reactions This response develops, as a rule, in patients who have had only 1-4 doses of meprobamate and have not had a previous contact with the drug Previous history of allergy may or may not be related to the incidence of reactions

Mild reactions are characterized by an itchy urticarial or erythematous, maculopapular rash which may be generalized or confined to the groin Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema, and fever have also been reported

More severe cases, observed only very rarely, may also have other allergic responses, including fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case), and hyperthermia Treatment should be symptomatic such as administration of epinephrine, antihistamine, and possibly hydrocortisone Meprobamate should be stopped, and reinstitution of therapy should not be attempted

Rare cases have been reported where patients receiving meprobamate suffered from aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia In nearly every instance reported, other toxic agents known to have caused these conditions have been associated with meprobamate A few cases of leukopenia during continuous administration of meprobamate are reported, most of these returned to normal without discontinuation of the drug

Impairment of accommodation and visual acuity has been reported rarely

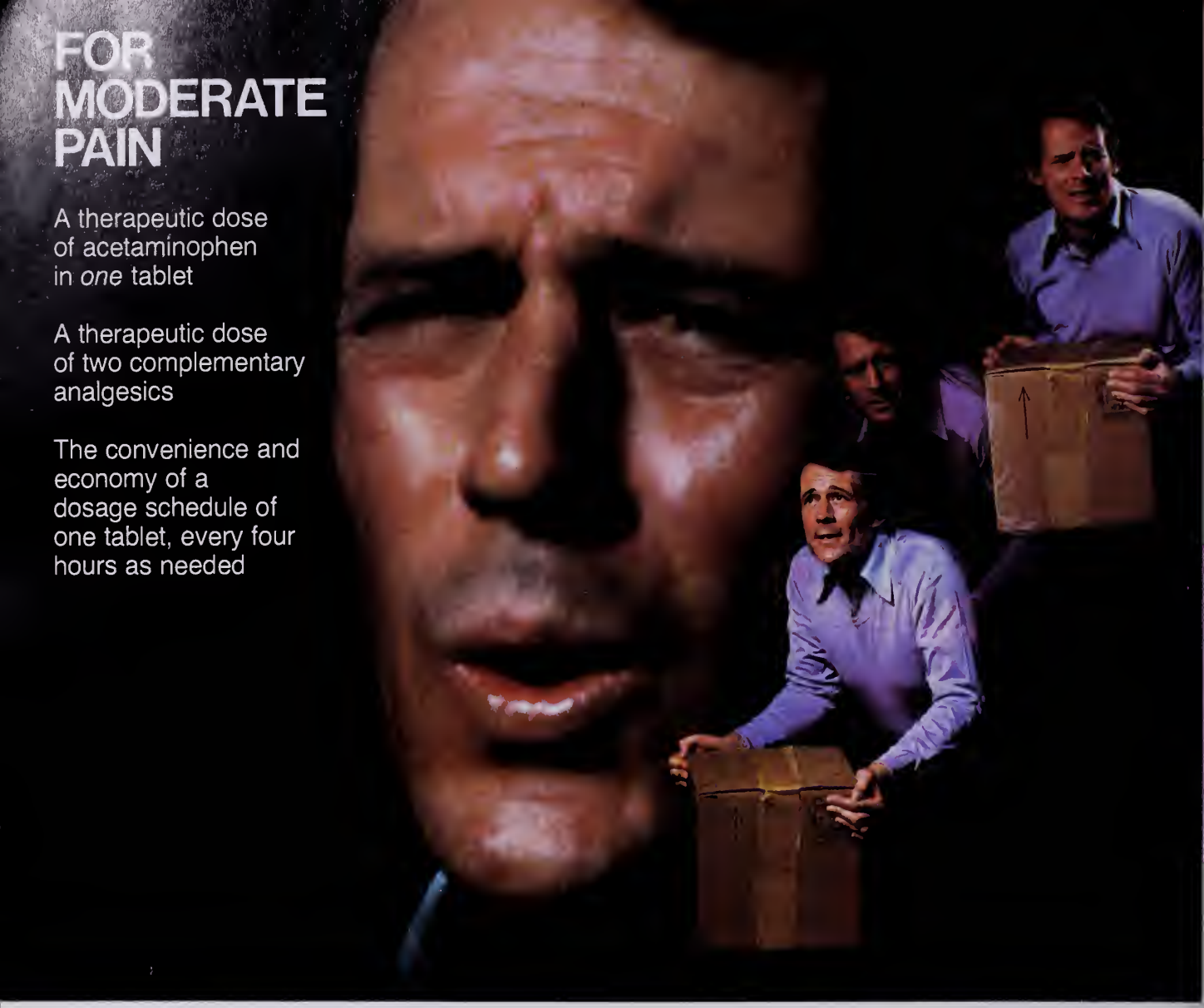
OVERDOSE: Two instances of accidental or intentional significant overdosage with ethoheptazine citrate combined with aspirin have been reported These were accompanied by symptoms of CNS depression, including drowsiness and light-headedness, with uneventful recovery However, on the basis of pharmacological data, it may be anticipated that CNS stimulation could occur Other anticipated symptoms would include nausea and vomiting Appropriate therapy of signs and symptoms as they appear is the only recommendation possible at this time Overdosage with ethoheptazine combined with aspirin would probably produce the usual symptoms and signs of salicylate intoxication Observation and treatment should include induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions

DESCRIPTION: Each Equagesic tablet contains 150 mg meprobamate, 75 mg ethoheptazine citrate and 250 mg aspirin

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INDICATION: For the relief of mild-to-moderate pain.

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WARNINGS: CNS ADDITIVE EFFECTS AND OVERDOSAGE Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, or other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. Toxic effects and fatalities have occurred following overdoses of propoxyphene alone or in combination with other CNS depressants. Most of these patients had histories of emotional disturbances or suicidal ideation or attempts, as well as misuse of tranquilizers, alcohol, or other CNS-active drugs. Caution should be exercised in prescribing large amounts of propoxyphene for such patients (see **Management of Overdosege**).

DRUG DEPENDENCE: Propoxyphene can produce drug dependence characterized by psychic dependence and less frequently, physical dependence and tolerance. It will only partially suppress the withdrawal syndrome in individuals physically dependent on morphine or other narcotics. The abuse liability of propoxyphene is qualitatively similar to codeine's although quantitatively less, and propoxyphene should be prescribed with the same degree of caution appropriate to the use of codeine.

USAGE IN AMBULATORY PATIENTS: Propoxyphene may impair the mental and/or physical abilities required for potentially hazardous tasks, e.g. driving a car or operating machinery. Patients should be cautioned accordingly.

USAGE IN PREGNANCY: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. INSTANCES OF WITHDRAWAL SYMPTOMS IN THE NEONATE HAVE BEEN REPORTED FOLLOWING USAGE DURING PREGNANCY. Therefore, propoxyphene should not be used in pregnant women unless, in the judgement of the physician, the potential benefits outweigh the possible hazards.

USAGE IN CHILDREN: Propoxyphene is not recommended for children because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric group.

PRECAUTIONS: Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine. The CNS depressant effect of propoxyphene may be additive with other CNS depressants, including alcohol.

ADVERSE REACTIONS: The most frequent adverse reactions are dizziness, sedation, nausea, and vomiting. These seem more prominent in ambulatory than in nonambulatory patients; some of these reactions may be alleviated if the patient lies down.

Other adverse reactions include constipation, abdominal pain, skin rashes, light-headedness, headache, weakness, euphoria, dysphoria, and minor visual disturbances. The chronic ingestion of propoxyphene in doses over 800 mg per day has caused toxic psychoses and convulsions. Cases of liver dysfunction have been reported.

DRUG INTERACTIONS: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, and other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended (see **Warnings**). Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine.

MANAGEMENT OF OVERDOSAGE: SYMPTOMS. The manifestations of serious overdosage with propoxyphene are similar to those of narcotic overdosage and include respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, pupillary constriction, and circulatory collapse. In addition to these characteristics, which are reversed by narcotic antagonists such as naloxone, there may be other effects. Overdoses of propoxyphene can cause delay of cardiac conduction as well as focal or generalized convulsions, a prominent feature in most cases of severe poisoning. Cardiac arrhythmias and pulmonary edema have occasionally been reported, and apnea, cardiac arrest, and death have occurred.

Symptoms of massive overdosage with acetaminophen may include nausea, vomiting, anorexia, and abdominal pain, beginning shortly after ingestion and lasting for 12 to 24 hours. However, early recognition may be difficult since early symptoms may be mild and nonspecific. Evidence of liver damage is usually delayed. After the initial symptoms, the patient may feel less ill; however, laboratory determinations are likely to show a rapid rise in liver enzymes and bilirubin. In case of serious hepatotoxicity, jaundice, coagulation defects, hypoglycemia, encephalopathy, coma, and death may follow. Renal failure due to tubular necrosis, and myocardiopathy, have also been reported.

Ingestion of 10 grams or more of acetaminophen may produce hepatotoxicity. A 13-gram dose has reportedly been fatal.

TREATMENT: Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation. The narcotic antagonists, naloxone, nalorphine, and levallorphen, are specific antidotes against the respiratory depression produced by propoxyphene. An appropriate dose of one of these antagonists should be administered, preferably IV, simultaneously with efforts at respiratory resuscitation and the antagonist should be repeated as necessary until the patient's condition remains satisfactory. In addition to a narcotic antagonist, the patient may require careful titration with an anticonvulsant to control seizures. Analeptic drugs (e.g. caffeine or amphetamine) should not be used because of their tendency to precipitate convulsions.

Oxygen, IV fluids, vasopressors and other supportive measures should be used as indicated. Gastric lavage may be helpful. Activated charcoal can absorb a significant amount of ingested propoxyphene. Dialysis is of little value in poisoning by propoxyphene alone. Acetaminophen is rapidly absorbed, and efforts to remove the drug from the body should not be delayed. Copious gastric lavage and/or induction of emesis may be indicated. Activated charcoal is probably ineffective unless administered almost immediately after acetaminophen ingestion. Neither forced diuresis nor hemodialysis appears to be effective in removing acetaminophen. Since acetaminophen in overdose may have an antidiuretic effect and may produce renal damage, administration of fluids should be carefully monitored to avoid overload. It has been reported that mercaptamine (cysteamine) or other thiol compounds may protect against liver damage if given soon after overdosage (8-10 hours). N-acetylcysteine is under investigation as a less toxic alternative to mercaptamine, which may cause anorexia, nausea, vomiting, and drowsiness. Appropriate literature should be consulted for further information. (JAMA 237:2406-2407, 1977)

Clinical and laboratory evidence of hepatotoxicity may be delayed up to one week. Acetaminophen plasma levels and half-life may be useful in assessing the likelihood of hepatotoxicity. Serial hepatic enzyme determinations are also recommended.

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Book Reviews

Book Review Editor — F. Norman Vickers, M.D.

A Psychiatric Glossary, Fifth edition, American Psychiatric Association. 142 Pages. Price $9.95. Little, Brown & Company, 34 Beacon Street, Boston, MA 02106. 1980.

The thousand or so words and concepts chosen for this glossary are both wide ranging and surprisingly inclusive. Each definition is uniformly clear, concise and precise. The more complex and technical concepts are supplemented by historical background data or ancillary information which helps fit the concept or term into a more meaningful gestalt.

A wealth of psychiatric information can be gleaned from simply perusing the words and definitions contained in the glossary. It is hard to believe the quantity of useful information that has been packed into this thin book.

With this glossary as a companion, the jargon in all but the most arcane articles in psychiatry can be made intelligible to the practicing physician or medical student. I agree completely with the book jacket endorsement which reads, *"A Psychiatric Glossary,* Fifth Edition, is an authoritative, thorough, and easy-to-use reference that will be of value to all physicians, medical students, nurses, and mental health workers."

In addition to the definitions, the glossary contains seven useful tables. The tables of legal terms and neurologic deficits should prove especially valuable to the practicing physician. In these two tables commonly used medico-legal and neurologic-deficit terms are collected and defined. You may be surprised to learn that there are at least 31 recognized "schools of psychiatry". The table of schools of psychiatry lists and names the schools with their respective founders.

The contributors and editors of this glossary are to be congratulated for this excellent production. It would make a valuable addition to any practitioner who has had difficulty deciphering the lingo in the articles on psychiatry that cross his desk.

Melvin P. Firestone, M.D.
West Palm Beach

Aequanimitas, Sir William Osler, 3rd edition, Blakiston McGraw Hill. Price $15.00. 449 Pages. 1906 (reprint).

Hardly a day goes by without a new book on "Medical Ethics". We are besieged by books on patient's rights, the failure of science to cure all ills, and the excess cost of Medical Care. It is well for this reason to read this series of Commencement Addresses, speeches and essays by William Osler, published here in a quality volume as a reprint of the 1906 edition.

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MEETINGS

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JANUARY

25th Annual Cardiovascular Seminar, Jan. 9-10, Sarasota-Longboat Key Holiday Inn, Longboat Key. For information: Mr. E. Jerry Eatman, Executive Director, American Heart Association, Suncoast Chapter, Inc., Box 12407, St. Petersburg 33733.

Hyperalimentation: Clinical Application, Jan. 12, Indian River Memorial Hospital, Vero Beach. For information: Dr. John Terry, 30 Royal Palm Boulevard, Vero Beach 32960.

Third Annual Winter Seminar of the Miami Ophthalmological Seminar, Jan. 11-18, Wildwood Inn, Snowmass at Aspen, Colorado. For information: David J. Singer, M.D., 1160 Kane Concourse, Miami Beach 33154.

IV Annual Review in Oral Pathology, Jan. 12-16, UM/Jackson Memorial Hospital/Mailman Center. For information: Division of CME, University of Miami School of Medicine, Box 016960, Miami 33101.

Neurological Update 1981, Jan. 14-18, Eden Roc Hotel, Miami Beach. For information: Division of CME, University of Miami School of Medicine, Box 016960, Miami 33101.

3rd Annual Walt Disney World Pulmonary Wintercourse, Jan. 15-18, Dutch Inn Resort Hotel, Walt Disney World, Lake Buena Vista. For information: Asher Marks, M.D., P.O. Box 8127, Jacksonville 32211.

16th Annual Pediatric Postgraduate Course, "Continuing Education in Pediatrics — 1981", Jan. 18-22, Diplomat Resorts, Hollywood Beach. For information: Dr. Donald H. Altman, Pediatric Postgraduate Course, Variety Children's Hospital, 6125 S.W. 31st, Miami 33155.

13th Annual Postgraduate Seminar in Pediatric and Adult Urology, Jan. 21-24, Konover Hotel, Miami Beach. For information: Victor Politano, M.D., 6614 Miami Lakes Drive, East, Miami Lakes 33014.

8th Annual Symposium in Pediatric Nephrology: Current Concepts in Diagnosis and Management, Jan. 25-29, Sheraton-Bal Harbour, Bal Harbour. For information: Jose Strauss, M.D., Division of Pediatric Nephrology (R-131), Box 016960, Miami 33101.

19th Annual Seminar "Imageology 1981", Jan. 25-30, Sheraton Bal Harbour, Miami Beach. For information: Lucy R. Kelley, c/o Miami Seminars, Box 343762, Coral Gables 33134.

Personality Adaptation Theory Used Working With Children and Adolescents, Jan. 30, Coronado Beach Resort, Fort Walton Beach. For information: John S. Waldo, A.C.S.W., 203 Beachview Drive, Ft. Walton Beach 32548.

2nd Annual Seminar "Practical Approaches to Diagnostic Problems in Radiology", Jan. 30-Feb. 2, Dutch Inn, Lake Buena Vista. For information: Lucy R. Kelley, c/o Miami Seminars, Box 343762, Coral Gables 33134.

Florida Society of Pathologists Annual Slide Seminar, Jan. 31-Feb. 1, Contemporary Building (Disney World), Lake Buena Vista. For information: C. F. McConnell, M.D., 5151 N. Ninth Avenue, Pensacola 32504.

7th Annual Vail Conference on Anesthesiology, Jan. 31-Feb. 6, The Mark Resort, Vail, Colorado. For information: Division of CME, University of Miami School of Medicine, Box 016960, Miami 33101.

FEBRUARY

6th Annual Review and Recent Practical Advances in Pathology, Feb. 1-6, Sheraton Bal Harbour, Bal Harbour. For information: Division of CME, University of Miami School of Medicine, Box 016960, Miami 33101.

Being an Effective Clinical Teacher, Feb. 2-6, Keystone, Colorado. For information: Division of CME, University of Miami School of Medicine, Box 016960, Miami 33101.

Florida Mid-Winter Seminar in Ophthalmology, Feb. 2-5, Doral Beach Hotel, Miami Beach. For information: Division of CME, University of Miami School of Medicine, Box 016960, Miami 33101.

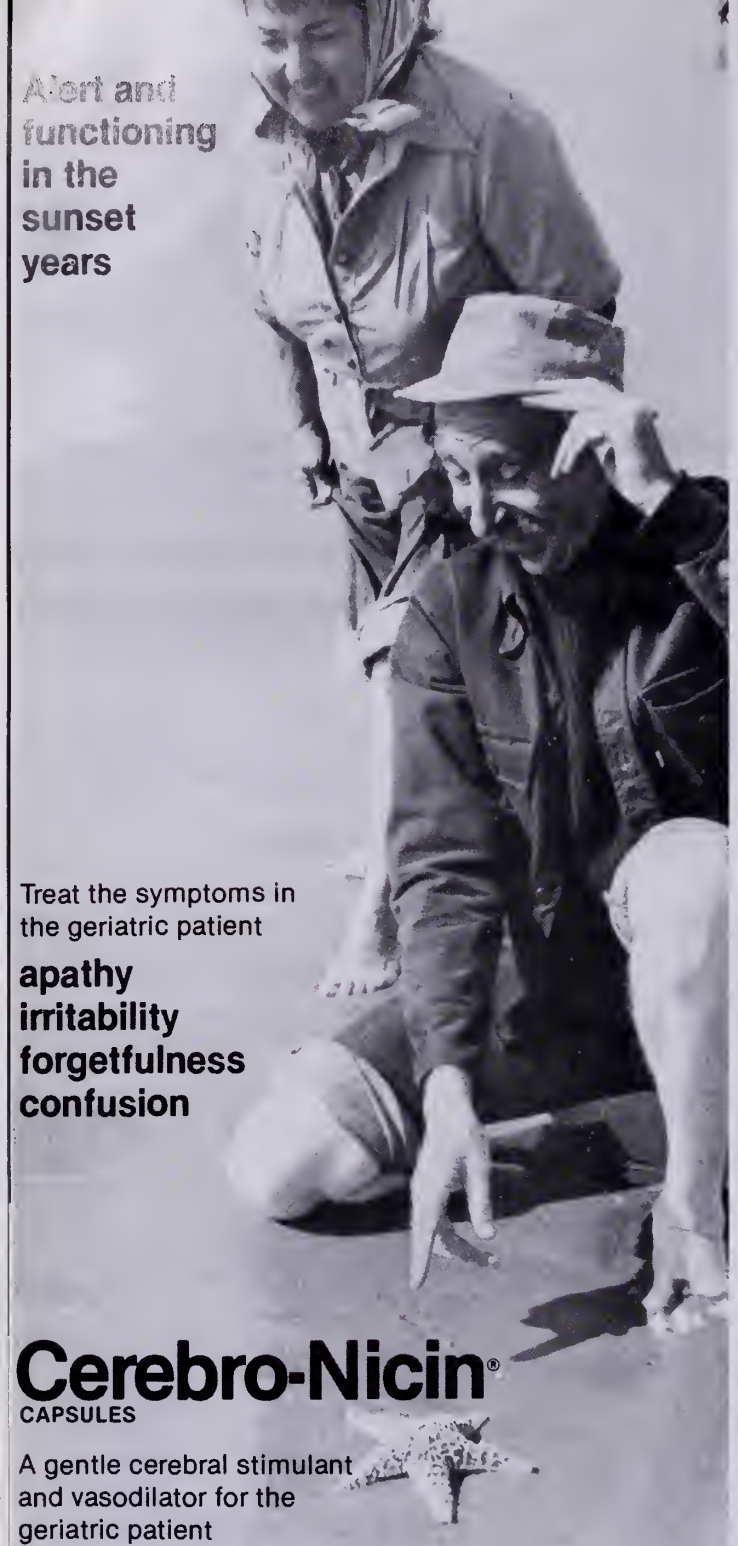
Cardiology at Walt Disney World, Feb. 5-8, Contemporary Resort Hotel, Lake Buena Vista. For information: Harold L. Greenberg, M.D., c/o AHA, Central Florida, P.O. Box 6665, Orlando 32853.

Florida Mid-Winter Seminar in Otolaryngology, Feb. 6-8, Doral Beach Hotel, Miami Beach. For information: Division of CME, University of Miami School of Medicine, Box 016960, Miami 33101.

John T. Dickinson Annual Symposium: Advanced Facial Plastic and Reconstructive Surgery, Feb. 6-8, Holiday Inn Oceanside, Vero Beach. For information: Facial Surgery Symposium, Ferdinard F. Becker, M.D., 777 37th Street, Suite C-101, Vero Beach 32960.

1981 Update in OB/GYN, Feb. 9-11, Disney World, Lake Buena Vista. For information: Frank Riggall, M.D., Department of OB/GYN, Box J-294, University of Florida College of Medicine, Gainesville 32610.

Conference on the Beach, 2nd Annual Family Practice Update, Feb. 16-21, Daytona Hilton, Daytona Beach. For information: Richard W. Dodd, M.D., Halifax Hospital Medical Center, Box 1990 Daytona Beach 32015.



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Florida Symposium on Micronutrients in Human Nutrition, Feb. 17-18, University of Florida, Gainesville. For information: James R. Kirk, Chairman, Food Science and Human Nutrition Department, University of Florida, Gainesville 32611.

Medical Update 1981, Feb. 18-20, Education Center, South Miami Hospital, South Miami. For information: Leonard Zwerling, M.D., c/o Continuing Education, South Miami Hospital, 7400 S.W. 62nd Avenue, South Miami 33143.

Stress and Chemical Dependency — Strategies for the 80's, Feb. 19-22, The Breakers, Palm Beach. For information: Jose Almeida, M.D., Medical Director, Daryl Kosloske, Executive Director, 1014 N. Olive Avenue, West Palm Beach 33401.

Teaching Conference in Clinical Cardiology, Feb. 25-28, Sheraton Bal Harbour, Bal Harbour. For information: Division of CME, University of Miami School of Medicine, Box 016960, Miami 33101.

Sixth Annual Midwinter Seminar in OB/GYN, Feb. 26-28, St. Petersburg Beach. For information: James M. Ingram, M.D., Department of OB/GYN, Box 18, College of Medicine, University of South Florida, Tampa 33612.

Pediatric Dermatology Seminar VIII, Feb. 26-Mar. 1, Eden Roc Hotel, Miami Beach. For information: Guinter Kahn, M.D., Suite 401, 16800 N.W. 2nd Avenue, North Miami Beach 33169.

Internal Medicine 1981 (16th Annual Postgraduate Course), Feb. 28-Mar. 6, Sheraton Bal Harbour, Bal Harbour. For information: Division of CME, University of Miami School of Medicine, Box 016960, Miami 33101.

MARCH

Being an Effective Clinical Teacher, Mar. 2-6, Sheraton Bal Harbour, Bal Harbour. For information: Division of CME, University of Miami School of Medicine, Box 016960, Miami 33101.

Comprehensive Review in Basic Neurology for Psychiatrists and Generalists, Mar. 2-6, Konover Hotel, Miami Beach. For information: Division of CME, University of Miami School of Medicine, Box 016960, Miami 33101.

Developmental Disabilities and Pediatric Practice, Mar. 5-7, Sheraton and Sand-Key Hotel, Clearwater Beach. For information: Mary G. Tenne, AAP, P.O. Box 1034, Evanston, Illinois 60204.

Oculoplastic-Orbital Update, Mar. 5-7, University of South Florida College of Medicine, Tampa. For information: James A. Rush, M.D., Box 21, 12901 N. 30th Street, Tampa 33612.

Problems in Rheumatology, Mar. 11-14, Don CeSar Beach Resort Hotel, St. Petersburg Beach. For information: Bernard F. Germain, M.D., Assistant Professor of Medicine, Director, Division of Rheumatology, Box 19, University of South Florida College of Medicine, 12901 North 30th Street, Tampa 33612.

Postgraduate Seminar in Dermatology, Mar. 12-14. For information: Division of CME, University of Miami School of Medicine, Box 016960, Miami 33101.

Orthopaedics for Family and Emergency Physicians, Mar. 18-21, Royal Plaza Hotel, Lake Buena Vista. For information: Allan W. March, M.D., Box J-222, JHM Health Center, Gainesville 32610.

Pediatric Orthopedics for Family Practitioners and Pediatricians, Mar. 22-25, Sheraton Bal Harbour, Bal Harbour. For information: Division of CME, University of Miami School of Medicine, Box 016960, Miami 33101.

American and European Views on Anesthesia, Mar. 22-27, Zermatt, Switzerland. For information: Division of CME, University of Miami School of Medicine, Box 016960, Miami 33101.

Current Clinical Concepts in Otolaryngology (in English and Spanish), Mar. 23-25, Eden Roc Hotel, Miami. For information: Division of CME, University of Miami School of Medicine, Box 016960, Miami 33101.

Postgraduate Course on Pediatric Orthopaedics for Family Practitioners and Pediatricians, Mar. 23-25, Sheraton Bal Harbour Hotel, Miami Beach. For information: Anthony Ballard, M.D., Course Chairman, Department of Orthopaedics and Rehabilitation, University of Miami School of Medicine, Box 016960, Miami 33101.

Toxic and Metabolic Liver Injury, Mar. 26, University of South Florida Medical Center, Tampa. For information: H. Worth Boyce, M.D., 12901 N. 30th Street, Box 19, Tampa 33612.

12th Annual Topics in Internal Medicine, Mar. 26-28, Gainesville Hilton, Gainesville. For information: Bill Rockwood, Box J-233, J.H.M. Health Center, Gainesville 32610.

Pan American Symposium on Trauma of Head and Neck (in English and Spanish), Mar. 26-28, Eden Roc Hotel, Miami Beach. For information: Division of CME, University of Miami School of Medicine, Box 016960, Miami 33101.

APRIL

Comprehensive Review Course: ECFMG, VQE, and FLEX (in Spanish), Apr. 6-July 17, UM/Jackson Memorial Hospital, Miami. For information: Division of CME, University of Miami School of Medicine, Box 016960, Miami 33101.

Atrial and Ventricular Arrhythmia Management Update, Apr. 16-18, Belleview Biltmore, Clearwater. For information: Bill Rockwood, Box J-233, J.H.M. Health Center, Gainesville 32610.

MAY

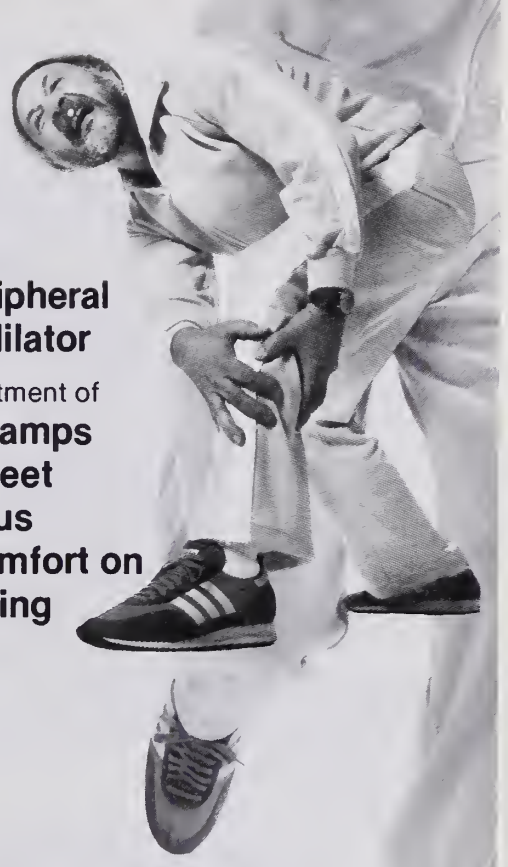
Human Sexuality, May 14-16, Gainesville Hilton, Gainesville. For information: Bill Rockwood, Box J-233, J.H.M. Health Center, Gainesville 32610.

Personality Adaptation Theory Used in Working With Couples and Families, May 22, Coronado Beach Resort, Fort Walton Beach. For information: John S. Waldo, A.C.S.W., 203 Beachview Drive, Fort Walton Beach 32548.

Master Approach to Cardiovascular Problems, May 29-31, The Contemporary Hotel, Walt Disney World, Lake Buena Vista. For information: Division of CME, University of Miami School of Medicine, Box 016960, Miami 33101.

JUNE

13th Family Practice Review, June 22-26, The Breakers, Palm Beach. For information: Bill Rockwood, Box J-233, J.H.M. Health Center, Gainesville 32610.



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Deaths

Archie, Edward O., Tampa; born 1893; Meharry Medical College, 1923; member AMA; died January 16, 1980.

Branning, Bowman W., Tavernier; born 1912; Yale University, 1937; member AMA; died 1980.

Corey, Arthur E., Orlando; born 1925; Tulane University, 1954; member AMA; died April 21, 1980.

Duke, R. Renfroe, Tampa; born 1884; University of Alabama, 1911; member AMA; died March 6, 1980.

Dumois, Juan Antonio, Tampa; born 1933; Havana University Medical School, 1960; died August 2, 1980.

Ghods, Cyrus Alexander, Ft. Lauderdale; born 1937; Middlesex Hospital — London, 1961; member AMA; died June 6, 1980.

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Harris, Harold Edward, Tampa; born 1912; Long Island College of Medicine, 1936; member AMA; died July 1, 1980.

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Jones, W. Wardlaw, Dade; born 1905; Emory University, 1928; member AMA; died April 29, 1980.

Kugel, Victor H., Miami; born 1905; Yale, 1929; member AMA; died July 3, 1980.

Laltoo, Joseph McCrorie, Palatka, born 1926, University of Bristol England, 1955; member AMA; died April 13, 1980.

Loriga, Martin S., Tampa; born 1921; University of Havana, 1950; member AMA; died April 5, 1980.

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Van Mierop, Lodewyk H. S., Gainesville 21-1
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Vickers, F. Norman, Pensacola 43-1
Vijayanagar, Raghavendra, Tampa 1002-11
Von Thron, Joseph C., Cocoa Beach 405-4

Walker, James W., Jacksonville 883-9
White, Mrs. James G., Ormond Beach 699-7
Wolf, Stewart G., Bethlehem, PA 52-1
Wright, Ronald K., Miami 134-2

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CLASSIFIED ADS

Physicians Wanted

FAMILY PRACTITIONER OR INTERNIST wanted to share facilities with three practitioners in solo practice. Major equipment provided. Rent $250 per month. Competent laboratory and x-ray departments with income based on use. Bookkeeping system and receptionist shared. Contact: T.C. Kenaston Jr., M.D., P.O. Box 550, Cocoa, Florida 32922.

TWO MAN OFFICE ON ANNA MARIA ISLAND needs high quality Family Physicians. New building, fully equipped with lab and x-ray. Exceptional opportunity for ownership. Contact E.P. Dickerson, M.D., 2010 59th Street West, Bradenton, Florida 33505, or call collect (813) 792-2211.

PRIMARY CARE and subspecialty physicians to join multispecialty group in South Palm Beach County. Excellent facilities. Compensation includes possibility of ownership in P.A. Send CV to Post Office Box 23606, Oakland Park, Florida 33334.

WANTED — Family Practitioner or Internist, Board qualified or Certified, to associate with two Certified Family Physicians in Coral Gables. Eventual partnership. H.M. Silberman, M.D., (305) 443-3001.

EXCELLENT OPPORTUNITY — for pulmonary and gastroenterology subspecialist in rapidly growing community on northern west coast of Florida with beautiful new office building adjacent to hospital. Enclose CV. Reply C-1012, Post Office Box 2411, Jacksonville, Florida 32203.

WANTED: OPHTHALMOLOGIST, INTERNAL MEDICINE, FAMILY PRACTITIONER, or PEDIATRICIAN to complement 14 other professionals in busy South Florida building. Write A. Mitchell, 3070 N.E. 47th Street, Fort Lauderdale, Florida 33308, phone (305) 772-2200.

EMERGENCY PHYSICIAN wanted for large hospital on Florida West Coast. E.R. Residency or 5 years experience preferred. 30 hour week. Fee for service. Send C.V. and date available to C-1020 Post Office Box 2411, Jacksonville, Florida 32203.

OPHTHALMOLOGIST WANTED to join Board Certified Ophthalmologist (age 36) in medium-sized northern Ohio city. Full partnership possible after one year. Liberal vacation and fringe benefits. Respond with C.V. to C-1021, Post Office Box 2411, Jacksonville, Florida 32203.

WANTED/ONCOLOGIST Central Florida, Excellent Opportunity. Please send C.V. to C-1022, Post Office Box 2411, Jacksonville, Florida 32203.

PATHOLOGIST — Immediate opening for associate, Board Certified, AP-CP, Florida license, strong background in Surgical Pathology. Forward C.V. to Melvin W. Clark, M.D., Department of Pathology, Alachua General Hospital, Inc., 801 S.W. Second Avenue, Gainesville, Florida 32602.

MODERN ER DEPARTMENT in Palm Beach County seeking full and part-time career oriented physicians for quality emergency care. Active community hospital with excellent physical facilities. Outstanding back-up staff in all specialties. Located in world famous resort area offering excellent cultural, recreational, and educational opportunities. Immediate appointments also available. Require Florida license and U.S. trained. Excellent compensation. All inquiries confidential. Respond with curriculum vitae and recent photo to: Palm Beach Emergency Associates, P.O. Box 15992, West Palm Beach, Florida 33406.

INTERNIST — Immediate opening for Board certified physician interested in joining a group of seven internists, established 25 years in a prestigious Ft. Lauderdale, Florida practice. Reply to B. L. Riehl, 3000 Bayview Drive, Ft. Lauderdale, Florida 33306, enclosing a C.V., or call (305) 565-4811.

Situations Wanted

BOARD CERTIFIED PREVENTIVE MEDICINE SPECIALIST: Florida licensed, in early 30's with more than 5 years experience in large Eastern health organization, seeks administrative / executive health position in large Florida health agency, insurance, or industrial corporation. Reply C-993, Post Office Box 2411, Jacksonville, Florida 32203.

PULMONARY INTERNIST, ABIM, University trained all phases of pulmonary medicine, seeks practice position, available July 1981. Reply Clifford Benezra, M.D., 15911 Godwin Court, Fountain Valley, California 92708. (714) 775-0142.

NEUROLOGIST, 35, seeking Florida opportunity. Competent in most neurodiagnostic and doppler techniques. Bilingual (English-Spanish), U.S. graduate and trained, AOA. Available July 1981. Reply C-1006, Post Office Box 2411, Jacksonville, Florida 32203.

INTERNIST-CARDIOLOGIST — FMG. Fully U.S. trained, 37, knowledge of Spanish, experience in stress testing, Echocardiography and all aspects of Clinical Cardiology and Internal Medicine. Available on short notice. Prefers Southwest or Southeast. Reply C-1015, Post Office Box 2411, Jacksonville, Florida 32203.

GENERAL AND COLON AND RECTAL Surgeon; Board Certified in both; Spanish speaking; U.S. trained; seeking relocation. Solo, partnership or group. Available 30 days notice. Please reply to Luis F. Zamora, M.D., 923 Reseda, Houston, Texas 77062.

UROLOGIST, 30, American graduate, Board eligible. Excellent training at large New York City Medical Center. Available July, 1981. Seeks group practice or partnership. Call (212) 876-5175.

PULMONARY INTERNIST, 33, ABIM and Pulmonary Board eligible, University trained in RICU, Swan-Ganz catheterization, Pulmonary lab, flexible bronchoscopy and consultations. Seeks group or hospital-based practice. Available July 1981. Please reply to 3822 N. Braeswood #5, Houston, Texas 77025.

LOCUM TENENS for allergist, consider having a week or two off or having your office open weekends. 10 years experience in conventional as well as Rinkel techniques. For curriculum vitae and reprints of articles published write: 11335 Southwest 152nd Terrace, Miami 33157.

PATHOLOGIST — Experienced general Pathologist with Florida license desires challenging position. Anatomic and Clinical Pathology Boards with subspecialty boards in chemical and radioisotopic pathology. Experience and interest in Forensic Pathology. Reply: C-1017,

P.O. Box 2411, Jacksonville, Florida 32203.

GASTROENTEROLOGIST, ABIM, completing university training. Desires practice opportunity. Available July, 1981. Dr. M. Freedman, 6351 Lebanon Avenue, Philadelphia, PA 19151. (215) 662-8477.

CARDIOLOGIST-INTERNIST, 29, Board Certified, excellent skills noninvasive and invasive Cardiology. Seeks solo, partnership or hospital based practice. Available summer '81. Please contact Rao Musunuru, M.D., 354 Henry St., Apt. 2, Brooklyn, N.Y., 11201. Telephone (212) 596-2986.

ENERGETIC 30 year old Certified by the American Board of Internal Medicine, Board eligible in Nephrology, desires a position as a Nephrologist. Available in July 1981. Reply C-1018, P.O. Box 2411, Jacksonville, FL 32203.

BOARD CERTIFIED ALLERGIST. University trained. Solo practice 15 years. Wishes to relocate. Florida group, VA, or association. Practice adult and pediatric allergy. Ready to move. Reply C-1023, Post Office Box 2411, Jacksonville, Florida 32203.

GENERAL SURGEON, 34, Board eligible, university trained, and experienced in vascular and trauma surgery, Florida license, seeking group practice, available July 1981. Reply: Dr. Behrend, 3410A Littlebrandt Drive, Ft. McClellan, AL 36205, or evenings (205) 820-3427.

COLORECTAL SURGEON to join group or partnership, available July 1981. Prefer Sarasota/St. Petersburg area. CV on request. Dennis A. Fried, M.D., Department of Colorectal Surgery, Cleveland Clinic.

Practices Available

FOR SALE: Established Family Practice office and equipment in growing community in Lake Okeechobee area, near West Palm Beach. Lovely home also available. Call collect (305) 924-5281 or (305) 683-6910.

28 YEAR established family practice, fully equipped; x-ray, EKG, etc., for sale. Southwest (Dadeland) area Miami. Lease transferrable. Will introduce. Good terms. Call (305) 270-1544 or (305) 596-6160.

GROWING PRACTICE FOR SALE. Internal Medicine in Fort Lauderdale. Excellent opportunity. Available immediately. Call (305) 491-7434.

GENERAL PRACTICE for sale or possible association. Same location 20 years. Best area Pinellas County. Dr. Gonzalez (813) 443-2104 after 7 p.m.

GENERAL PRACTICE FOR SALE — Established general practice in lucrative area of Southwest Florida; building two years old, fully furnished and equipped. Practice and office suitable for two doctors. Office based practice retiring. Contact C-1019, P.O. Box 2411, Jacksonville, FL 32203.

FOR SALE: Established Family Medicine Practice in growing community in St. Petersburg, Florida. Excellent staff and location. Reply: (813) 251-4035.

Real Estate

OUTSTANDING LOCATION FOR SPECIALISTS: St. Nicholas Medical Center. Central location, off street parking and all utilities furnished (including janitor service). Contact W. G. Allen Jr., Owner-Manager, St. Nicholas Medical Center, 3127 Atlantic Boulevard, Jacksonville, Florida 32207. Phone (904) 398-5500.

JACKSONVILLE 1,500 square feet, medically designed office. A/C; ample parking, stable, middle income residential community in N.W. Jacksonville. Some equipment available. Start at $250 per month. (305) 446-4284.

DURANGO, COLORADO: Magnificent 35 to 40 acre Ranchsites on 2,000 acre ranch. Only a few left. From $3,000 per acre. Will finance. Incredible hunting on property. Year 'round recreation, fabulous skiing. Russell Yates, Beaver Creek Ranch, P.O. Box 2433, Durango, Colorado 81301. Telephone (303) 259-2680.

WEST PALM BEACH AREA — Doctors Office. Complete office, fully equipped with practice available. Lot 100x73, building included. Excellent value. M. Dolnick, (305) 746-9600. The Berg Agency, Inc.

MIAMI — LEASE 2,000 square feet medical office available at $8.50 per square foot. Going rate in area $11.00 to $12.00 per square foot. Excellent location. Near hospitals and expressway. (305) 595-4281.

OFFICE FOR RENT, square footage variable. Exquisitely equipped and maintained. 2250 S. Dixie Highway, Miami, Florida (305) 856-5170.

MEDICAL SUITES, West Palm Beach. Sized and built to need. Adjoining Community Hospital of Palm Beaches. Community Professional Building, 2151 45th Street, (305) 842-5023.

PALM BAY, FLORIDA: Space Available in new "Port Malabar Professional Center". Opening in summer, 1981. South Brevard County is booming with new business, families, and opportunities. Now with preconstruction prices and free custom designing. Call Donald L. Kane, D.D.S., Phone (Business) (305) 773-6666, (Home) (305) 254-3694.

VAIL CONDO — two bedroom, kitchen, living room, fireplace, beautiful view. $525.00/week. Contact Ralph Bloch, M.D., 9950 W. 80th Avenue, Arvada, Colorado 80005, (303) 425-0961 or 399-9076.

Equipment

FOR SALE — Olympic Fiberoptic Bronchoscope, used two times. All attachments. Excellent condition. $3,000 firm. Contact L. C. Taylor, M.D., 320 Parkview Place, Lakeland, Florida 33801. Phone (813) 682-4913.

Art

FINE ART. Major paintings by modern and contemporary masters. DeKooning, Johns, Kelly, Lictenstein, Louis, Oldenburg, Pollock, Rauschenberg, Twombly, Warhol and others. By appointment only. Marvin Ross Friedman & Col, 15451 Southwest 67 Court, Miami, Florida 33157. (305) 233-4281.

Service

MEDICAL APPRAISAL SERVICE — Appraisals made to form P.A.'s, on all surgical and office equipment. Fast service, 40 years experience. Reply to Post Office Box 14498, Orlando, Florida 32857.

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Advertising Rates Increase Effective January 1

The Journal's **classified advertising base rate will remain the same in 1981 ($10.00 for the first 25 words or less, additional words 25 cents each).**

New rates for display advertising, effective January 1, are available upon request, and reflect a 10% increase.



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For recurrent attacks of urinary tract infection in women

Bactrim™ DS Double Strength Tablets

Each tablet contains 160 mg trimethoprim and 800 mg sulfamethoxazole.



Just one tablet b.i.d. for 10 to 14 days

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- Low incidence of bacterial resistance in community practice
- Convenient *b.i.d.* dosage provides day-and-night antibacterial control
- Contraindicated during pregnancy and the nursing period. During therapy, maintain adequate fluid intake; perform CBC's and urinalyses with microscopic examination.

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* **It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination.** *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

The recommended quantitative disc susceptibility method (*Federal Register, 37*:20527-20529, 1972) may be used to estimate bacterial susceptibility to Bactrim. A laboratory report of "Susceptible to trimethoprim-sulfamethoxazole" indicates an infection likely to respond to Bactrim therapy. If infection is confined to the urine, "Intermediate susceptibility" also indicates a likely response. "Resistant" indicates that response is unlikely.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; pregnancy; nursing mothers; infants less than two months of age.

Warnings: Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L. E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

Urinary Tract Infections: Usual adult dosage—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days.

Recommended dosage for children—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. A guide follows:

Children two months of age or older

Weight		Dose—every 12 hours	
lbs	kgs	Teaspoonfuls	Tablets
20	9	1 teasp. (5 ml)	½ tablet
40	18	2 teasp. (10 ml)	1 tablet
60	27	3 teasp. (15 ml)	1½ tablets
80	36	4 teasp. (20 ml)	2 tablets or 1 DS tablet

For patients with renal impairment:

Creatinine Clearance (ml/min)	Recommended Dosage Regimen
Above 30	Usual standard regimen
15-30	½ the usual regimen
Below 15	Use not recommended

Pneumocystis carinii pneumonitis: Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets,* each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100. *Tablets,* each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40, available singly and in trays of 10. *Oral suspension,* containing in each teaspoonful (5 ml) the equivalent of 40 mg trimethoprim and 200 mg sulfamethoxazole, fruit-licorice flavored—bottles of 16 oz (1 pint).

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The probability of recurrent urinary tract infection appears to be enhanced by the establishment of large numbers of *E. coli* or other urinary pathogens on the vaginal introitus. The trimethoprim component of Bactrim diffuses into vaginal fluid in effective concentrations, thus combating migration of pathogens into the urethra.

Studies have shown that Bactrim acts against *Enterobacteriaceae* in the bowel without the emergence of resistant organisms. Thus, Bactrim reduces the risk of introit colonization by fecal uropathogens. It has *no* significant effect on other normal, necessary intestinal flora.

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